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Community Based Distribution of Family Planning:
Perspectives from Kabarole, Uganda

by

Annette Flaherty



A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment
of the requirements for the degree of Master of Science

Medical Sciences - Public Health Sciences

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University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *Community Based Distribution of Family Planning: Perspectives from Kabarole, Uganda* submitted by Annette Flaherty in partial fulfillment of the requirements for the degree of Master of Science in Medical Sciences – Public Health Sciences.

For Salima and Joey,
whose loving hearts and welcoming home
made thesis completion a pleasant endeavour.

ABSTRACT

This study assesses community perceptions of, and experiences with, the Community Based Distribution (CBD) Family Planning Program in Kabarole, western Uganda. Both quantitative and qualitative methods were employed. Questionnaires were administered to CBD Volunteers (n=70) and active clients (n=49). Focus group discussions (n = 7) and interviews (n=8) were held with active and former CBD Volunteers, in-school adolescents, CBD Trainers and local government representatives. Findings revealed an overall acceptance and appreciation of the CBD program and its role in increasing family planning accessibility and acceptability in Kabarole. However, CBD program impact appears constrained by a web of complex and interacting factors including community challenges (such as male and religious opposition and misconceptions and fears about family planning) and program-related problems (such as lack of incentive schemes for volunteers and inadequate training, education materials and field supervision). Suggestions are offered for increasing family planning acceptance as well as CBD program impact and sustainability. The urgent need to prioritize adolescents' access to reproductive health education and services is also addressed.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ADF	Allied Democratic Front
BHS	Basic Health Services
CBD	Community Based Distribution
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DHMT	District Health Management Team
FP	Family Planning
GTZ	German Technical Cooperation
HIV	Human Immuno-deficiency Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
LC	Local Council
LRA	Lord's Resistance Army
MOH	Ministry of Health
NRM	National Resistance Movement
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organization

OPERATIONAL DEFINITIONS

Abstinence – refraining from sexual intercourse (Reproductive Health Outlook, 2000).

Community Based Distribution (CBD) of Family Planning – a non-clinic strategy that relies on trained community members to take safe and simple contraceptive methods (such as oral pills or condoms) and family planning education and information to people within their community rather than requiring people to visit clinics for these services (Best, 1999).

Community Based Distribution (CBD) Trainer – in the context of the Kabarole district CBD program, a CBD Trainer is a group leader responsible for overseeing a sub-county CBD program. CBD Trainers are generally female nurses employed at the sub-county health unit. CBD Trainers do not receive any financial remuneration for their participation in the CBD program and CBD responsibilities are supplementary to their regular health centre nursing duties.

Community Based Distribution (CBD) Volunteer – in the context of the Kabarole district CBD program, a CBD Volunteer is a male or female family planning service provider, also known as an agent, a distributor of family planning information and supplies or a CBD. CBD Volunteers are selected from the communities in which they serve and are not remunerated for their services.

Contraceptives / Family Planning methods – methods used by males or females to prevent pregnancy.

Contraceptive Prevalence Rate (CPR) – the percentage of currently married or “in-union” women of reproductive age (15-49) who are currently using contraception.

Depo Provera Injections – a very effective, injectable contraceptive containing the hormone progesterin. To prevent pregnancy, an injection (in the buttocks or upper arm of females) is given every three months (Family Health International, 2001).

Developing Countries/World – countries in the world (generally Asia, Africa and Latin America) in which the majority of the population (though not necessarily all) struggle to meet their basic, daily needs. An ideal or internationally agreed-upon term does not exist to adequately define the circumstances in these countries nor their relative comparison to economically richer or more industrialized nations. Other (equally inadequate) terms often used to describe developing countries include: Third World, underdeveloped countries, lowest income nations and The South.

Family planning – actions taken by males or females to plan their families by choosing freely the number, timing and spacing of their children.

Female Condom - a thin, soft, loose-fitting, polyurethane plastic (which is stronger than latex) pouch that lines the vagina. The flexible inner ring at the closed end is inserted into the vagina. The outer ring remains outside the vagina and covers the external genitalia. It is female-controlled but requires the support and acceptance of male partners. It can prevent both pregnancy and STDs/ HIV when used consistently and correctly (Family Health International, 2001).

Foam Tablets – spermicides or chemical barriers that are inserted into the female vagina before sexual intercourse in order to inactivate sperm, making fertilization unlikely. Foam tablets can be used alone or in combination with another contraceptive method (Family Health International, 2001).

Female Sterilization (tubal occlusion) – a surgical procedure where the fallopian tubes, which carry the egg from the ovary to the uterus, are blocked (tied and cut, cauterized, or interrupted by ring or clip). Sterilization ends fertility permanently (Family Health International, 2001).

Gender – culturally defined roles and responsibilities for females and males that are learned, may change over time, and vary among societies (Reproductive Health Outlook , 2000).

Intrauterine Devices (IUD) – a small plastic device inserted into a woman's uterine cavity to prevent pregnancy. The IUD containing copper is the most commonly used and is effective for up to ten years (Family Health International, 2001).

Male Condom - a thin sheath usually made of rubber (latex) that is placed on an erect penis before intercourse. As a contraceptive, male condoms serve as a physical barrier preventing sperm from entering the female reproductive tract. Male condoms can prevent both pregnancy and STDs/ HIV when used consistently and correctly (Family Health International, 2001).

Modern Contraceptive Methods – contraceptive methods that depend on the use of products, devices or surgery include pills, IUDs, injections, condoms, spermicides and sterilization.

Natural Methods of Family Planning – prevent sperm from uniting with an egg by avoiding intercourse around the time of ovulation or by withdrawing the penis from the vagina before ejaculation (Family Health International, 2001). Natural or non-modern methods can also include herbal, folk or other traditional methods to prevent pregnancy.

Norplant Implants – a contraceptive system that consists of six small flexible capsules of progestin. Each capsule is about the size of a matchstick. The capsules are inserted just under the skin on the inner side of a women's upper arm using a minor surgical procedure (a general anesthetic is usually given). They provide highly effective contraception for up to five years (Family Health International, 2001)

Oral Contraceptives (The Pill) – temporary, female contraceptive method in the form of pills which are swallowed once a day to prevent pregnancy. Combined Oral Contraceptives contain the hormones estrogen and progestin. Progestin-only pills do not contain any estrogen and are especially effective for breastfeeding women (Family Health International, 2001).

Permanent Methods: minor surgical procedures that permanently terminate fertility in men (vasectomy) or women (female sterilization) (Family Health International, 2001).

Quality Care – includes courteous, supportive interactions that help clients express their needs and make informed choices and the technical knowledge and skills to provide family planning methods and other reproductive health care effectively and safely (Hatcher et al, 1997).

Reproductive Health – this concept implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (Hatcher et al, 1997).

Reproductive Rights – this concept rests on the recognition of the basic right of all couples to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health (Hatcher et al, 1997).

CHAPTER 1 – INTRODUCTION

Family planning – the ability of females and males to plan their families by choosing freely the number, timing and spacing of their children – is increasingly recognized as a fundamental freedom and a basic reproductive right. The 1994 International Conference on Population and Development (ICPD) in Cairo gave an important impetus to the recognition of individuals' rights to be informed about family planning and to have access to safe, effective, affordable and acceptable methods of family planning (Evans and Huezo 1997; Hatcher et al, 1997). By identifying family planning information and services as a critical means for the articulation and attainment of reproductive health (Hatcher et al, 1997), the ICPD has inspired re-examinations of the impact of family planning on health and renewed interest in service delivery models that can effectively and appropriately meet the family planning needs of individuals and couples in the developing world.

1.1 Impact of Family Planning on Health

Family planning is said to be one of the most effective investments for helping ensure the health and well-being of women, children, families and indeed, whole communities (World Health Organization, 1997). Using contraceptives to space or limit births can reduce infant and child mortality and promote child survival by reducing the risks of malnutrition and disease (Planned Parenthood Federation of America, 1999). Couples with fewer and healthier children are able to devote more resources to providing their families with adequate food, clothing, housing and educational opportunities. Communities, in turn, can benefit from reduced strain on community and environmental resources (e.g. health, education and water, firewood and energy) placing them in a more favorable position to promote sustainable social development. Additionally, from a public health perspective, barrier forms of contraceptives, such as condoms, are critical to prevention efforts relating to the spread of sexually transmitted infections, including HIV/AIDS (Planned Parenthood Federation of America, 1999).

It has been widely documented that family planning offers clear health benefits to women (World Health Organization 1997; Planned Parenthood Federation of America, 1999; Best, 1998; Williamson, 1998). The ability to delay first birth and space or limit future births is especially beneficial to high-risk groups of women such as those under 18 or over 35 years of age, women with more than four children, or those with existing health problems (World Health Organization, 1997). In developing countries, where complications related to pregnancy and childbirth are a

common cause of illness and death, family planning not only improves women's health but also saves their lives (World Health Organization, 1997; Best, 1998). Expanding access to family planning services can help women avoid unwanted pregnancies, many of which end in illegal, dangerous or unsafe abortions (World Health Organization, 1997). More than one fifth of all live births in developing countries are said to be mistimed or unintended (Cleland, 1997). Unwanted births are at their highest in societies where the level of contraceptive use lies in the range of 20 to 50%. When contraceptive use rises above 50%, however, the incidence of unwanted births falls, with substantial benefits in terms of obstetric morbidity and mortality (Cleland, 1997).

Relief from the burden of childbearing and rearing can also improve psychological well-being, particularly if family planning offers freedom from fear of pregnancy or improves sexual life, partner relations and family harmony (Planned Parenthood Federation of America, 1999; Best, 1998). Besides the direct impact of family planning on women's health, attention is also being paid to the impact of family planning on the multiple domains of women's lives – individual, family and household, as well as economic, community and societal (Williamson, 1998; Hong and Seltzer, 1998). By allowing women to decide on the number and spacing of their children, family planning programs have the potential to enhance the quality of women's lives in numerous areas including personal autonomy, self-esteem and empowerment; educational attainment; employment and economic resources; family relationships; and participation in community and social activities (Best, 1998; Williamson, 1998).

1.2 Family Planning Impact is Influenced by Multiple Health Determinants

The impact family planning can have on a woman's health and quality of life is influenced by a complex web of interactions among various factors. The availability of a family planning program in a woman's community will certainly be a major determinant of her health. However, various characteristics and elements of that particular family planning program will need to be taken into account when assessing impact. These include accessibility and quality of services, the degree to which family planning is integrated with other health and development programs, the nature and extent of family planning Information, Education and Communication (IEC) activities and policies affecting the political and financial support for the program (Hong and Seltzer, 1998). A program that focuses on clients' family planning concerns and needs, for example, is more likely to enhance the positive impacts of family planning than one concentrating solely on reaching demographic targets.

A woman's individual characteristics - age, economic situation, marital status and educational level, as well as the number, sex and age of her children and her life cycle stage - can affect her decision to use contraception and her method choice, thereby increasing or decreasing the potential positive benefits of family planning (Hong and Seltzer, 1998). For example, family planning may not make much difference in terms of future educational and employment opportunities for a woman who already has six children. In contrast, a woman's decision to delay her first baby until after she finishes her schooling can dramatically affect her educational level and future employment prospects (Hong and Seltzer, 1998). Other personal, family and community factors (which are, in turn, often culturally prescribed) that deserve consideration include attitudes towards preventive practices; misconceptions, beliefs and knowledge related to conception and contraception; susceptibility to sexually transmitted diseases including HIV; fears about the health risks of contraceptives and communication with spouse.

Gender and gender norms, or the roles prescribed by society for women and men, play a significant role in shaping women's family planning experiences (Williamson, 1998). Gender roles can have negative effects on contraceptive use and reproductive health for both sexes, although often more profoundly for women. Gender often operates in conjunction with other social classifiers such as class, culture, family and religion - where the pressing challenges of moral, familial and social acceptability of family planning can come into play (Williamson, 1998; Hong and Seltzer, 1998). These factors can include family systems that promote or discourage high fertility and son preference; cultural preference and perceived economic need for large families; traditional and religious attitudes, beliefs and behaviors about sex, conception and contraception or; cultural and class barriers to family planning in the clinic setting (Williamson, 1998; Hong and Seltzer, 1998).

Additionally, social, cultural, micro and macro political and economic factors can affect all aspects of women's lives and the impact of family planning. These include, among others, geographic isolation; political insecurity; religious climate; influence yielded by traditional healers and village chiefs; economic environment, poverty and debt, the availability of educational, employment and other opportunities such as civic consultation on community health issues; decentralization of health services as well as the differential access to resources by various segments of society (Hong and Seltzer, 1998).

Whether or not women using contraceptives have more influence in making household decisions than those not using family planning varies widely from one community to another. However, family planning employees in various countries report helping their husbands to make decisions, including decisions about their daughter's age of marriage and their own contraceptive use (Best, 1998).

While a consideration of the interplay of these multiple factors illustrates the potential benefits and positive impact family planning can have for women, it also elucidates the potential costs to women. For example, when partners or family, including in-laws, are opposed, family planning can actually increase women's vulnerability, particularly to domestic violence (Hong and Seltzer, 1998). Covert use of contraceptives, generally resulting from real or perceived male opposition or difficult spousal communication about family planning, may entail negative personal implications for the woman and programmatic obligations to ensure client confidentiality. New and difficult challenges may be faced by a woman who chooses to have a smaller family, particularly if it means she will lose the security or status of traditional family or societal roles (Williamson, 1998). As well, the concern over contraceptive side effects, real or perceived, may serve as an additional burden for women (Williamson, 1998; Hong and Seltzer, 1998).

1.3 Increasing Access to Family Planning

In the developing world, a variety of approaches have been explored and implemented to ensure that women and men who are interested in using contraceptives to space or limit births can readily find a source of family planning information, supply and support. Initial strategies included building additional clinics in under-served areas and providing mobile family planning clinics. Accessibility to family planning extends beyond geography, however. Even when service delivery points are physically accessible and affordable, poor conditions such as limited hours, long waits, rude treatment by clinic staff or unreliable supply of contraceptives may pose barriers to access (Reproductive Health Outlook, 2000). Medical barriers at the family planning site, such as outdated contraindications, provider bias, eligibility restrictions based on age or parity or process hurdles that force clients to make additional visits can also limit use of services (Speizer et al, 2000; Reproductive Health Outlook 2000).

In consideration of these potential restrictions, some initiatives have broken free from the medical model of provision and focused on training private sector providers or employing social marketing schemes to enhance the sale of contraceptives in pharmacies or other retail outlets

(Cleland, 1998). Although effective in some areas, such initiatives fail to address obstacles to family planning that may be rooted in the cultural or social context of the client – fear of disapproval by family and neighbours, fear of side effects, community misconceptions regarding contraceptives, male opposition, marriage and family structure as well as gender inequities leading to women's lack of negotiating or decision-making power regarding fertility preferences (Reproductive Health Outlook, 2000; Blanc et al, 1996). Recent survey data from both Pakistan and the Philippines determined that it was these social costs of contraception (such as fear of side effects and spousal opposition) that served as decisive obstacles to its use, not monetary or direct costs of obtaining supplies (Shelton et al, 1999). Clearly, innovative approaches which have the potential of addressing geographical barriers and affordability as well as the multitude of possible obstacles to family planning information and services in the developing world are essential.

1.4 The Community Based Distribution Approach

Community Based Distribution (CBD) of family planning, which relies on community input and involvement, is a non-clinic strategy designed to increase access to reproductive health services, specifically family planning, for underserved people living in poverty (Finger, 1999a). CBD services have been observed to improve access to family planning and increase contraceptive prevalence in countries throughout the developing world (Katz et al, 1998; Best 1999). While there are many variations, community based distribution programs, in general, rely on trained community members to take safe and simple contraceptive methods (such as oral pills, condoms or other barrier methods) and family planning education and information to people within their community rather than requiring people to visit clinics for these services (Best, 1999). A fundamental element of CBD programs is that CBD agents are normally selected by, and answerable to, the community in which they live.

1.5 Research Questions and Specific Study Objectives

In the primarily rural district of Kabarole in western Uganda, women have expressed a need for family planning – one assessment reports that 48% of women say they do not want more children yet they are not using contraceptives. In an attempt to respond to this unmet need for family planning, a Community Based Distribution Family Planning program was initiated by the local Primary Health Care Project, Basic Health Services (BHS). At present, there are approximately 500 trained CBD Volunteers bringing family planning information and safe and simple contraceptives to villagers in Kabarole district. While obviously contributing to increased accessibility and acceptability of family planning in the district, service delivery through CBD

remains low and the desired impact has yet to be realized. BHS has identified the need for an assessment of community perspectives of the CBD program and considers community suggestions for improvement indispensable in realizing program priorities to improve and expand the family planning and reproductive health services available in Kabarole.

This present study was therefore designed, in collaboration with BHS staff, to answer three general questions about the CBD program in Kabarole:

- 1) What are community perceptions of, and experiences with, the CBD family planning program in Kabarole?
- 2) Based on these local perspectives, what are the reasons for the constrained impact of CBD in Kabarole?
- 3) How can these perspectives be incorporated into suggestions for strengthening the CBD program?

Through the use of both qualitative and quantitative approaches, this study sought to:

- ascertain community (primarily female clients' and Volunteers') perceptions* of, and experiences with, the CBD family planning program in Kabarole;
- assess perceptions of the barriers or constraints faced by clients and CBD Volunteers in receiving and providing CBD family planning services;
- ascertain how these perceptions impact the sustainability of the CBD program;
- appraise the knowledge and service provision approaches of CBD Volunteers;
- identify community perceptions and suggestions about how the CBD program can be improved to better meet community needs and to ensure the continued availability and use of services;
- make suggestions, specifically those that are within the present resource capacity, that will contribute to the improvement of the CBD family planning services available in Kabarole.

* Perceptions include perspectives, conceptualizations, attitudes (satisfaction and dissatisfaction), experiences and understanding as well as perceived importance of services.

CHAPTER 2 – THEORETICAL ORIENTATION

2.1 Overview

Theoretical frameworks are “orientations or sweeping ways of looking at the social world. They provide collections of assumptions, concepts and forms of explanation” (Neuman, 2000, p 59). Neuman advocates that there is no need to force all thinking into a single theory and that frameworks can include an array of formal or substantive theories that share assumptions and major concepts (Neuman, 2000).

The incorporation of a multidimensional approach to theoretical paradigms, as defined above, appears warranted by the complex interaction of variables affecting how community based family planning services are provided and received by the Kabarole community. Indeed, a variety of assumptions, perspectives, ideologies and theoretical premises have guided and influenced all phases of this research project.

2.1.1 Perspectives and Principles

This study employs, and acknowledges the benefits of incorporating, both a gender-sensitive and contextualist perspective in gathering community perceptions of the CBD program and in interpreting study findings (Barnett, 1999). Having a gender-sensitive perspective means being aware of, and accounting for, the plethora of gender-related factors that may affect the collection and interpretation of data (Kitts and Hatcher, 1996). A gender-sensitive approach to family planning may examine such factors as strategies to increase male participation; women’s roles as being primarily responsible for family planning, childbearing and rearing; level of women’s activism and decision-making ability; and the interaction between gender-based abuse and family planning.

Insights into gender encourage family planning providers to view reproductive health as a family and social health issue as well as a women’s health issue (Paulson, 1998). They can also encourage family planning programmers to address the dynamics of knowledge, power and decision-making within sexual relationships, between providers and clients and between community or political leaders and citizens (Paulson, 1998).

Research derived from a contextualist perspective encompasses the belief that people should be listened to and understood from within their own experience and from within their own points of

view (Richman et al, 2000). This study recognizes and values the voices and opinions of those typically marginalized or ignored by society. It views CBD clients' and Volunteers' perspectives as legitimate sources of knowledge and recognizes these perceptions as valid, relational and contextual (Reutter et al, 1995). The voices and views, no matter how eloquently or awkwardly expressed, as well as the non-articulated aspects of lives of poor female clients and struggling CBD Volunteers are considered indispensable in the present effort to improve the quality and quantity of the CBD program in Kabarole (Schuler and Hossain, 1998).

A critical analytical orientation is warranted by the belief that family planning in this rural setting in sub-Saharan Africa is inextricably linked to issues of gender, equity, power, resource distribution as well as to the institutional level influences on people's, particularly women's, reproductive choice. Selected feminist principles that reflect the general concepts of critical theories have served as an ideological backbone for this study. As described by Reutter et al, these include recognition of the cultural and social context, responsiveness to the vulnerable, participation and equality, celebration of diversity, prevalence of participants' perspectives and empowerment of participants (Reutter et al, 1995). These principles are also congruent with the concepts of international primary health care and sustainable human development. It is also important to acknowledge that these principles are fortified by the researcher's previous experience with community development initiatives in the developing world, her preference for community based solutions and her personal commitment to employing gender sensitive and participatory approaches to community development.

2.1.2 Incorporating the Organization-Development Tradition

It is perhaps this personal commitment to participatory approaches that led to the application of an organization-development approach in this study. Simmons provides the following description of this approach:

Within the organization-development tradition, research is undertaken as a way to accomplish organizational improvement with the help of outside agents or catalysts. Working in close collaboration with members of the organization, researchers diagnose organizational problems and identify possible interventions. Organization development efforts are undertaken in concurrence with the leaders of the organization, often upon their invitation, and therefore tend to reflect the concerns of management (Simmons and Elias, 1994, p 7).

This research project was undertaken as part of a historical and ongoing collaboration between Basic Health Services (BHS) and University of Alberta Associate Professor, Dr. Walter Kipp, and

his graduate students. Such collaborative efforts shape the very nature of the research process at almost every phase – including the initial identification of the research topic, the questions asked, as well as the development and implementation of resulting recommendations. Because the research process was internally oriented, i.e. oriented towards BHS and CBD program needs and not overridden by the academic goals of the researcher, joint ownership of the research process was fostered. For the researcher, this liaison required ongoing contemplation of her dual loyalties and responsibilities both as a partner in the collaborative research effort and as an ambitious MSc candidate.

2.1.3 Determinants of Health Approach

Population Health focuses on the entire range of individual and collective factors and conditions, and the interactions among them, that determine people's health (Health Canada, 1996). An underlying assumption in this study is that a Population Health Approach is as applicable in the developing world as it is in Canada. A central argument of this study is that variables impacting an individual client's decision to use family planning cannot be distinguished from the social, political and programmatic context in which CBD Volunteers attempt to promote and distribute those services (Gammeltoft, 1999). An exploration of the complex web of interactions of family planning (discussed in more detail in the first introductory chapter) with other mediating determinants and contextual influences is as inherent in an assessment of perceptions about CBD as it is in the development of suggestions to improve service delivery. Therefore, a guiding principle of this study is that, with a deeper understanding of the determinants, their interactions and contextual influences, as explored from the perspective of clients and service providers, the Basic Health Services CBD program and its subsequent impact can improve (Edwards, 1999).

2.1.4 Connecting Determinants to Service Delivery

This research has involved the dual consideration of the contextual factors affecting client and volunteer participation in the CBD program as well as the attributes of the specific delivery system. Indeed, it has been a combination of operations research, that is, an investigation concerned with the effectiveness of a health delivery system (Wawer et al, 1985) and a quasi-ethnographical assessment of people's perspectives of, and experiences with, CBD in the particular cultural setting of Kabarole. A final underlying theoretical premise, therefore, is that an engagement between the two forms of knowledge considered here is not only possible but essential if communities, particularly women, in the developing world are to achieve better sexual and reproductive health (Gammeltoft, 1999). Since, ultimately, research on determinants is

intended to guide the development of interventions, the deliberation throughout the research and writing process has been how to use the emerging evidence about the determinants affecting Kabarole people's perspectives and preferences for CBD to guide the development, improvement and prioritization of the family planning program (Edwards, 1999).

CHAPTER 3 – BACKGROUND INFORMATION

3.1 Uganda

Simultaneously referred to as “the Pearl of Africa” and “one of the world’s poorest countries,” Uganda boasts fantastic natural scenery, fertile soils, abundant water sources as well as a stifling international debt and a turbulent history of military tyranny, atrocities and bloodshed. Located in the heart of East Africa, this small land locked nation, covering an area of just 236,580 square kilometers (Finlay et al, 2000), is surrounded by Sudan, Kenya, Tanzania, Rwanda and The Democratic Republic of Congo. Maps of both Africa and Uganda are found in Appendices 1 and 2, respectively.

Uganda’s population is roughly 23 million people, 47% of whom are under the age of 15 (Population Reference Bureau, 1999). It is comprised of a complex and diverse range of tribes, the largest being the Buganda whose traditional land is the area to the north and north-west of Lake Victoria, including the capital city of Kampala. While the official language of the country is English, there are more than 40 languages spoken in Uganda (Grimes, 1996). Other major languages include Luganda, Swahili, Ateso and Luo (Finlay et al, 2000). About two thirds of Ugandans are Christian (primarily Catholics and Protestants though Evangelicals are gaining in numbers, particularly in poorer areas of the country). There is also a small but growing minority of Muslims (16%) and a variety of traditional religions based around the powers of spirits, ancestors and the natural world (Finlay et al, 2000).

3.1.1 History

Uganda was established as a British protectorate soon after the colonialists started showing an interest in East Africa in the mid 19th century. At the time of its independence from Britain in 1962, Uganda was supposedly an emerging success story enjoying rapid agricultural growth. “Progress” was dramatically reversed in the upcoming decades, however, thanks largely to a string of sordid regimes and tyrants. Perhaps most internationally well known and condemned was Idi Amin’s reign of terror that included everything from the expropriation of businesses and expulsion of the Asian community to the decimation of tribes and the torture and slaughter of hundreds of thousands of Ugandans. The turbulence continued after Amin was ousted in 1979 as subsequent despots, such as the notorious Milton Obote, took turns pushing the country further down the path of destruction and chaos. Physical infrastructure had crumbled and the economy,

along with the education and health systems had totally collapsed by the time Yoweri Museveni and his National Resistance Movement (NRM) came to power in 1986 (World Bank, 2000).

3.1.2 Politics

Widely credited with re-establishing political stability and rebuilding the country's economy, infrastructure and social systems, (New Internationalist, 1996) Yoweri Museveni and the NRM continue to hold power in Uganda. The first ever Presidential and Parliamentary elections were held in 1996 with Museveni capturing almost 75% of the vote (World Bank, 2000). Succeeding elections held in March 2001, declared fair by international observers, also demonstrated overwhelming popular support for Museveni.

The government is composed of broad-based political groupings brought together under the country's no-party political system (World Bank, 2000). Though turnout was low, a national referendum held in June 2000 found 90% of voters in favour of Museveni's no-party Movement system over a pluralist/multi-party system. At the base of the NRM political administration are the Local Councils (or local governments), administrative bodies elected by and accountable to the communities they serve and charged with the responsibility of mobilizing resources to deal with local problems. While capacity building is needed, these Local Councils provide an opportunity for ordinary local people to develop democratic practice and self-reliance (New Internationalist, 1995).

The Ugandan government's commitment to economic and political stability is continually undermined by rampant corruption and political insurgency both within and outside Uganda. Domestic concerns include the Lord's Resistance Army (LRA) and the Allied Democratic Front (ADF). The fighting between LRA Christian fundamentalist rebels and the Ugandan army forces has displaced, injured and killed thousands and had a devastating effect on the social and economic life of Ugandans in the north of the country near the Sudan border. The ADF have been waging a low intensity war (attacking villages, destroying homes, raiding harvests, displacing and killing) in and around the Rwenzori Mountains in southwest Uganda, including Kabarole district where this study is set. Both the LRA and the ADF are reported to recruit by terror, often abducting children who are forced to become soldiers, servants or concubines (Sebunya, 1998). Ostensibly to ensure border security, Ugandans also find themselves involved in costly and unnecessary events beyond their borders, particularly in the Democratic Republic of Congo (DRC). The fighting in the DRC has also ended Uganda's earlier alliance with Rwanda since

Uganda and Rwanda now support rival rebel factions in the DRC (Finlay et al, 2000). For Uganda, and indeed for the entire continent of Africa, genuine development in the fields of education and healthcare will remain seriously constrained as long as politicians are unwilling to put people before politics (Finlay et al, 2000).

3.1.3 Economy

Agriculture is the most important sector of the Ugandan economy, employing between 80 and 90 percent of the work force (World Bank, 2000). Coffee is the major export crop followed by tea, sugar, cotton and tobacco. Crops grown for local consumption include matooke (bananas), maize, millet, cassava, sweet potatoes, beans and cereals. Women are responsible for up to 80% of the agricultural production, which involves both subsistence and cash crops, though major control of production decisions and income generated rests with men (Baden and Wach, 1998).

Uganda has emerged as a “robust economic performer” and is presently cited as having one of the fastest growing economies in Africa (World Bank, 2000). It is considered a darling of the International Monetary Fund (IMF), having embraced its recommended economic reforms (New Internationalist, 1995). Encouraging economic trends have not, however, translated into improvements in living conditions for the very poorest Ugandans. There is a widening gap between the beneficiaries of the new economic policy and the sizeable proportion of the population who are getting poorer (New Internationalist, 1995). Thanks largely to the heavy burden of vast international debt - despite being the first country to receive a World Bank and IMF approved debt relief package in 1998 - Uganda remains one of Africa’s poorest countries with an annual gross national product of USD \$300 per capita* and approximately 46% of the population living in absolute poverty (New Internationalist, 1997; Ministry of Health, 1999).

3.1.4 Healthcare in Uganda

Poverty is recognized by the Ugandan Ministry of Health to be the main underlying cause of the poor health situation in the country. Associated factors are the low levels of literacy (estimated at 74% for men and 50% for women), high prevalence of communicable diseases, emergence of lifestyle-related diseases, inadequate provision and inequitable distribution of social services and the general level of underdevelopment of service infrastructure (Ministry of Health, 1999).

* As compared to USD \$3,210 per capita for South Africa, \$160 for Sierra Leone and \$370 for India.

The Poverty Eradication scheme of the Ugandan government includes agriculture, water and sanitation, Primary Health Care and a Universal Primary Education Program (which has led to a more than doubling in enrollment in primary school levels but has unfortunately not resulted in a corresponding increase in schools or teachers).

In response to health care management, organization and financing problems, decentralization of the health care delivery system, whereby management and budgetary powers are devolved to local governments instead of a highly centralized management and authority, has been given high priority. Inadequate funding of the health sector remains a problem with total per capita health expenditure in the range of USD \$7 to \$12, with only \$3.95 attributed to government and donor spending, the balance coming from individual out of pocket payments (Ministry of Health, 1999). The ominous influence of giant financial institutions such as the World Bank is felt in this regard. The Bank, because of its enormous money-lending capacity, has been able to force its health blueprint (slashed budgets, privatization of medical services and the instigation of unofficial user fees) on Uganda as it has in most poor countries of the developing world (Werner, 2001). Ugandans' poor healthcare situation is further aggravated by inefficient allocation of available resources (more than 63% of the budget and 54% of trained staff are concentrated in hospitals while there is an over-dependence on untrained personnel in primary health care facilities), low staff morale arising from poor remuneration and weak management (Ministry of Health, 1999).

3.1.5 Basic Health Indicators

Life expectancy in Uganda is a modest 42 years. Eighty-one infants die for every 1000 live births and 13% of children die before reaching age five (Population Reference Bureau, 1999). At the top of the list for national death burden are perinatal and maternal conditions, malaria, acute lower respiratory tract infections, AIDS, diarrhea, tuberculosis and malnutrition. The Ministry of Health reports that geographical access to health care has been limited to about 49% of the population i.e. people living within five kilometers of a health service unit and that rural communities are particularly underserved (Ministry of Health, 1999). The population per doctor is estimated at 25,000 (Population Information Network, 1998).

3.2 Reproductive Health in Uganda

Uganda has one of the highest population growth rates in sub-Saharan Africa. Annual population growth is estimated at three percent, doubling the population in only 23 years, from 23 million to 46 million (Population Information Network, 1998). Total fertility rate is seven children per woman (Population Reference Bureau, 1999; Centre for International Health Information, 1999). By 2010, the number of women in their childbearing ages is expected to increase 35%, from four to five and a half million (Durbin, 1997). International Family Health reports that Ugandan women have a one in 26 chance of dying from a maternity-related cause (International Family Health, 2001).

Reproductive health indicators for adolescents are particularly appalling. The 1995 Uganda Demographic and Health Survey reported that, by age 15, almost one third of girls interviewed had experienced their first sexual encounter (Hulton et al, 2000). Unprotected sexual activity offers the risk of HIV infection as well as mistimed pregnancies - the level of adolescent pregnancy is among the highest in the world (Hulton et al, 2000). More than half of females are mothers before the age of 18 (Hulton et al, 2000; Population Information Network, 98). Sixty-six percent of women give birth by the age of 20 (The New Vision, 2000). One third of girls drop out of school annually due to unwanted pregnancies (The New Vision, 2000). Abortion as a method of contraception is illegal and unsafe or botched abortions continue to claim the lives of Ugandan women and girls. The Family Planning Association of Uganda estimates that 60% of abortion related complications are among 15-24 year olds (Kabwa, 2000).

Family planning is not a new concept in Uganda - activities began as early as 1957 with the establishment of the Family Planning Association of Uganda, an affiliate of the International Planned Parenthood Federation (Agyei and Migadde, 1995). Wholehearted support or advocacy for family planning from top government officials, including the President, however, is not as evident in Uganda as it is in the neighbouring country of Kenya. In fact, in October 2000, the Buganda Kingdom Minister for Community Works, was quoted as asking the Baganda people (the most populous tribe of Uganda comprising 17% of the population) to desist from family planning for fear that their population numbers were getting too low (Kabwa, 2000). Although the influential President Museveni has never expressed vehement opposition, family planning initiatives would undoubtedly be bolstered by a more positive, proactive and sympathetic government stance.

Despite the launch of a comprehensive national population program in 1995 and its lofty objectives to provide sexual and reproductive health services to the population, the promotion of modern contraceptives through family planning services continues to be inadequate. While the contraceptive prevalence rate (CPR) for married women (for all methods) improved from five percent to 15% between 1991 and 1995, CPR for modern methods for all women is estimated at only eight percent and may be as low as five percent in rural areas where the majority (85%) of Ugandans live (Ministry of Health, 1999; Centre for International Health Information, 1999; Lutalo et al 2000). Access barriers are particularly significant in rural areas, where only 39% of the population are reported to live within five kilometers of any facility offering family planning services, compared with 99% of the urban population (Wolff et al, 2000). The Ugandan Demographic and Health Survey estimated that only 34% of the total demand for family planning was met by services available in 1995 (Lutalo et al, 2000).

Uganda has been cited as the success story in Sub-Saharan Africa in its efforts to reduce HIV prevalence levels. Despite the lack of political will to blatantly advocate for family planning, the Ugandan government, driven by President Museveni, was the first in Africa to acknowledge that it had an epidemic on its hands and to initiate intensive educational campaigns designed to promote safer sexual behaviour (the predominant mode of transmission is sexual intercourse) and curb the spread of HIV (Collymore, 1999). Median HIV prevalence of antenatal clinic attendees outside of Kampala has declined from 13% in 1992 to eight percent in 1998 and declines have been even more dramatic for women ages 15 to 19 years (United Nations AIDS/World Health Organization, 2000). Despite the efforts and advances, over 100,000 Ugandans died of AIDS during 1999 (United Nations AIDS/World Health Organization, 2000). An estimated 820,000 Ugandan adults (aged 15-49) and children were HIV infected at the end of 1999, about half of them female (United Nations AIDS/World Health Organization, 2000). HIV/AIDS continues to have a devastating economic and social impact on every facet of life in Uganda, affecting agriculture and the public sector, health care and education systems. Household structure and family relations have also not been spared and there are currently almost one million orphans under the age of 15 who have lost their mother or both parents to AIDS (United Nations AIDS/World Health Organization, 2000).

3.3 Kabarole District

This study was conducted in Kabarole district located in southwestern Uganda, close to the Democratic Republic of Congo border (please refer to map of Uganda in Appendix 2). As found in other districts of Uganda, Kabarole is subdivided into a hierarchical administrative system and political structure consisting of six counties, 35 sub-counties*, 177 parishes and approximately 1500 villages. Fort Portal town, four to five hours drive from the capital Kampala and set in the foothills of the Rwenzori mountains, serves as the district headquarters.

Kabarole district is home to close to one million people, the majority of whom live in rural areas and survive on subsistence farming. Ethnically, being the heartland of the Kingdom of Tooro, the district is primarily occupied by the Batooro though other ethnic groups include the Bakiga, Banyankole, Banyarwanda, Batagwineda, Bafumbira and Bakonjo (Baguma, 2000). Tribes differ in local dialect and culture, including traditional beliefs regarding sex and marriage, but share the common language of Rutooro. English is also widely spoken, particularly by health professionals and within Fort Portal town.

3.3.1 Healthcare in Kabarole

Decentralization of the national health care system means that responsibility for the provision of health services in Kabarole falls to the Ministry of Health District Health Management Team (DHMT). Basic Health Services (BHS) is a Primary Health Care Project that is implemented by the DHMT but has received technical and financial support from the German Agency for Technical Cooperation (GTZ) since 1988.

Initially concentrating on the reconstruction of health infrastructure, capacity building and the establishment of basic health services, BHS Project efforts have also targeted HIV/AIDS, onchocerciasis, malaria, tuberculosis and childhood diseases as well as promoting maternal health and family planning. Project achievements are reflected in the improvement of general health indicators, most noteworthy the reduction of HIV/AIDS. The BHS Project, which has been attempting to shift responsibilities from the GTZ core staff to the DMHT since 1998, is now in its fifth and final phase and complete handover to the local counterpart is planned for December 2001.

* The political structure functioning at the sub-county level is the Local Council 3 or LC3.

3.3.2 Reproductive Health in Kabarole

According to 1999 Kabarole district data, infant mortality is at 86 per 1000 live births, child mortality is 129 per 1000, average annual growth rate is 3.3% and the total fertility rate is eight children per woman – all poorer than national figures (District Health Management Team, 2000a). While antenatal clinic attendance (at least one visit) is approximately 80%, only 18% of deliveries were conducted by trained personnel in 1999 (Waisa, 2000; District Health Management Team, 2000b). HIV rate of infection has been steadily declining, particularly amongst young people, but the prevalence for 15-24 year olds (both urban and rural) is still unacceptably high at 14.8% in 1999, compared to national rate of nine and a half percent (District Health Management Team, 2000b).

There are more than 60 rural health facilities scattered throughout the district. This includes three hospitals, though all are located in Fort Portal town. Sixty-six percent of health units report to provide family planning services (District Health Management Team, 2000b). However, one reported estimate is that only 26% of the population is within five kilometers of a health unit (Waisa, 2000). A 1997 Kabarole survey found that 48.1% of women intended to use, but were not yet able to use family planning services (Kilian et al, 1997). Approximately five percent of Kabarole women use modern contraceptives (Ferguson, 1998). Low literacy levels (particularly amongst women), negative cultural practices and beliefs, pro-natalist attitudes, polygamy and early marriages are some of the factors affecting the acceptance levels of family planning in Kabarole (Population Information Network, 1998; Ferguson, 1998).

Ferguson, who completed an assessment of the reproductive health situation in Kabarole in 1998, reported that, despite the challenges, numerous pre-conditions for enhancing family planning initiatives exist in the district. He reports that, although detailed information about family planning is lacking, many women in the district demonstrate a basic knowledge and interest. While traditional preferences for large families are still apparent in Kabarole, the biggest barriers inhibiting acceptance for family planning appear to be a) women's lack of specific and correct information about methods and side effects and b) a lack of knowledgeable family planning agents to provide this information and counter rumours and misconceptions resulting from the lack of information (Ferguson, 1998).

The improvement and expansion of family planning and reproductive health services has been prioritized in the present BHS Project phase (1999-2002). A principal challenge faced by BHS

staff is one commonly experienced by health managers attempting to achieve multiple, sometimes conflicting, objectives in severely limited resource settings. On the one hand, the BHS family planning program strives to reach as many people as possible, particularly the socio-economically and geographically disadvantaged. On the other, BHS must try to meet the needs of individual clients by consistently offering high quality care (Reproductive Health Outlook, 2000).

3.4 Community Based Distribution of Family Planning

Community based distribution (CBD) of contraceptives began in the early 1970s when it initially became apparent that the family planning needs of large segments of the population in developing countries were not being met by existing services provided by doctors or nurses in clinics or health centres. A main reason was a severe shortage of trained medical personnel, particularly those outside hospitals or urban centres. This problem persists today with most developing countries reporting tens of thousands of people per physician, nurse or nurse-midwife. Additionally, clinic based services, if available at all, were, and continue to be, too far away, costly, time consuming or socially or culturally inappropriate for many potential family planning clients.

Perhaps not surprising, one of the greatest obstacles to the initial implementation of CBD in many developing countries was the reluctance, on the part of Ministries of Health and other authorities, to accept the presumed risks of oral contraceptives being distributed by lay people with little formal education (Osborn and Reinke, 1981). Field trials eventually indicated that non-clinical services, including the screening for oral contraceptives, could be provided safely by nonprofessionals as long as they were adequately trained and supervised (Evans and Huezo, 1997; Shelton et al, 1999). Despite initial obstructions, CBD projects pioneered throughout the 1970s and 1980s and demonstrated not only that trained lay people or non-professionals could provide contraceptives safely, but also that they could significantly increase contraceptive use in relatively short periods of time (Shelton et al, 1999). Pilot studies in Kenya and Mali have since demonstrated that, when assessed for their ability to screen pill clients and give adequate information to pill users, CBD agents were just as competent as nurses (Population Council, 1998).

Following the initial implementation of CBD programs, local community distribution agents began to be recognized not only as suppliers of contraceptives but also for their ability to activate dormant demand for family planning (Simmons et al, 1986). By the early 1980s it was being

argued that, since the process of contraception adoption requires education, persuasion and behaviour change, extension strategies (vs. clinic based approaches) utilizing local agents were ideally placed to stimulate, oversee and guide the process (Simmons et al, 1986). The CBD literature at this time suggested that CBD programs may be most useful under those circumstances not generally considered conducive to family planning efforts, such as low contraceptive use or extensive unmet need (Osborn and Reinke, 1981; Phillips et al, 1996). In 1988, Simmons et al concluded that CBD agents, if appropriately selected and trained, could not only meet unmet need for demand for contraceptives by providing convenient supply but they could also play a role in reducing fear of contraceptive technology, addressing religious barriers and high fertility preferences as well as mobilizing male support for family planning (Simmons et al, 1988). In Bangladesh, for example, researchers found that the role of the community based family planning worker “transcends the boundaries of what is conventionally implied by the concept of supply” and that she is a “change agent whose presence helps to shift reproductive decision making away from passivity” (Simmons et al, 1988, p 29).

Similar praises for the utilization of local workers are heard today. Recent research from Uganda has noted that, since one of the greatest hurdles to interspousal communication about sensitive topics such as family planning or sexually transmitted diseases is bringing up the subject for the first time (usually for fear of invoking suspicion of infidelity or weakened commitment to the union), CBD agents can legitimately introduce these topics with couples, thereby reducing the social cost of such discussions (Wolff et al, 2000). Additionally, it has been noted that, since timely visits by CBD workers may also enable clients to more effectively manage side effects or be referred for an alternative method, CBD agents can be instrumental in facilitating contraceptive continuation (Finger, 1999a). Indeed, by utilizing community members and promoting community involvement, CBD programs offer the potential of increasing *accessibility* as well as social *acceptability* of FP.

3.4.1 Community Based Distribution in Uganda

According to the literature, CBD programs did not begin on a wide scale in Uganda until 1996. A 1995 study of the demographic and sociocultural factors influencing contraceptive use in Uganda concludes with a recommendation for efforts to be made to train local field workers to provide contraceptives, monitor clients for side effects and make referrals. It notes that “field workers selected from their communities could play a leading role especially in reassuring people about the safety of contraceptives, other than them relying on the rumours about side effects” (Agyei

and Migadde, 1995, p 59). At present, small scale CBD initiatives in several areas of the country are being supported by the Ugandan Ministry of Health (with assistance from the United Nations Population Fund, UNFPA), the Family Planning Association of Uganda, Pathfinder International, Delivery of Improved Services for Health (a joint project of Government of Uganda and United States Agency for International Development), Care International and of course, German Technical Cooperation (GTZ) and the District Health Management Team in Kabarole. It is perhaps because CBD is still in its infancy in Uganda that there appears to be a dearth of published literature on the strengths and weaknesses of CBD initiatives in that country.

3.4.2 Community Based Distribution in Kabarole District

Recognizing that family planning services in the district were not satisfactory, and upon advice from the GTZ Family Planning project in Kenya where a large scale CBD program was taking place, Basic Health Services first initiated community-based distribution of family planning in 1991. Although a total of 177 CBD Volunteers were trained at six sites in the district from 1992 to 1994, only about 15% of these are still active, the remainder having dropped out. The failure of this first initiative is attributed to many factors including almost negligible demand for family planning at that time; lack of an effective information, education and communication campaign; a weak, centralized system of supervision and support; and the inability of CBD agents to sell contraceptives as initially proposed. Following the study tour of a successful CBD project in Kenya, a second CBD initiative was implemented in 1997 (Ferguson, 1998). Although this second recruiting and training endeavour proved more successful than the first, the CBD program has yet to realize its desired impact, anticipated service delivery or full potential.

To date, there are CBD sites operating in 24 sub-counties within Kabarole district (refer to map of CBD sites in Appendix 3). The number of CBD Volunteers operating in each sub-county ranges from six to 30, with an average of 22 CBD Volunteers per site. Officially, this involves over 500 CBD agents. However, a worrisome number of these agents is either partially active, completely inactive or do not report consistently. While initially only female CBD Volunteers received training, many more men have been recruited and trained in recent years. Presently, BHS estimates that about 40% of the active CBD Volunteers are male. The majority of clients are female but the number of male clients continues to rise.

Couple years of protection (CYP) for oral contraceptives* achieved by CBD Volunteers in 1999 is crudely assessed at 1000 as compared to 4464 CYP achieved in health units and 2569 CYP achieved by the Family Planning Association of Uganda Kabarole division (District Health Management Team, 2000b).

It is reported that CBD Volunteers, as compared to static health units, contributed to 60% of the pills and 71% of the condoms distributed in Kabarole district for the period January to June 2000 (Baryomunsi, 2000). CBD Volunteers officially reported referring over 110 individuals to health units for Depo-Provera injections in 1999. An examination of service delivery on a per CBD basis is less favourable however. Only one CBD site has CBD Volunteers reporting more than 10 client contacts per month.

The identification of CBD sites depends on both the expressed need of communities and the perceived need as indicated by periodic community health assessments. Once a CBD site is identified, the sub-county health unit staff receives an orientation to CBD services. Ideally two, but typically one, health unit staff (most always a female nurse) is identified to oversee the CBD program. Once identified, these health unit nurses, known as CBD Trainers, participate in a Training of Trainers course organized and facilitated by the BHS reproductive health staff. CBD Trainers do not receive any financial remuneration for their participation in the CBD program and CBD responsibilities are supplementary to their regular health centre nursing duties.

Health centre staff and key Local Council Leaders work together to sensitize and mobilize other community leaders who, in turn, assist in the further sensitization of communities about family planning and the CBD program. It is these community members who identify potential individual CBD Volunteers, generally one to two per village. Given the high attrition of CBD Volunteers, attempts are made to recruit two CBD Volunteers per village to ensure that at least one is available. The average number of households covered by a CBD Volunteer is estimated to be between 40 and 80, depending on the population density and the patterns of the CBD Volunteer location (Ferguson, 1998).

* Distributing 13 cycles of oral contraceptives produces one CYP since that many pills provide one year of protection. It is acknowledged that CYP cannot and should not be solely relied upon as a measure of CBD program effectiveness or CBD Volunteer effort.

Selection criteria for CBD Volunteers include residence in the area to be covered, literacy (at least in local language), ability to keep simple records and a willingness to work as a volunteer. The potential agent can be male or female but should be respected within the community, appreciative of confidentiality issues and have the time and motivation to provide services to the community. Minimum or maximum age restrictions are not specified.

Once the CBD Volunteers have been identified and the CBD Trainer has completed her Training of Trainers orientation, a two-week, non-residential, training course is offered to CBD Volunteers at the sub-county level. A Ministry of Health approved training curriculum, which has been translated into the local language of Rutooro, is used. Training is designed, at least in theory, to include refresher courses and field follow-up.

At the end of the initial training, each CBD Volunteer receives an official certificate of training, a shoulder bag and badge displaying the CBD program name and logo, referral cards and contraceptive supplies (pills, condoms and foam tablets). All CBD Volunteers and Trainers are supposedly given a set of colorful, illustrative flipcharts entitled “Planning Your Family” to assist them with community education. However, because of budgetary constraints, replenishment of initial supplies is long overdue.

The main duties of CBD Volunteers are to provide family planning education to communities, visit households, recruit and counsel potential clients, distribute contraceptives to accepting clients, refer clients for other methods not offered by CBD Volunteers, compile and submit monthly activity reports and attend monthly meetings at the sub-county health unit. CBD Volunteers do not receive any monetary incentives for their efforts and are not regularly provided with lunch or travel allowances to attend monthly meetings. Arrangements have been made to ensure that CBD Volunteers receive fast (i.e. they do not have to queue) and free services when requiring health services at the sub-county health centre. However, this incentive does not appear to be consistently honoured by all health centre staff.

A limited number of CBD groups have attempted to initiate small-scale income generating projects such as brick making or weaving. A few groups also operate small and often sporadic revolving loan funds. The schemes differ depending on the group but generally mean that individual CBD Volunteers make fixed donations at the beginning of their monthly reporting meetings, those in need of a loan state their requests and reasons for a loan and the group

collectively decides who can take how much home. The loan is paid back with minimal interest within a specified timeframe thereby making more money available for loans to other eligible CBD Volunteers.

While the BHS Reproductive Health Coordinator makes frequent, albeit unscheduled, visits to sub-county health units, particularly during CBD monthly reporting meetings, field visits by BHS staff to CBD Volunteers in their community settings are rare. The CBD Trainer serves as the communication conduit between CBD Volunteers and BHS staff. CBD Trainers are primarily responsible for field supervision of CBD Volunteers. A system is in place to reimburse CBD Trainers for fuel expenses related to field supervision but a regular schedule for supervision or a standard reporting system is not utilized.

CHAPTER 4 – LITERATURE REVIEW

The following literature review is composed of two main sections: 1) trends in family planning research and 2) lessons learned from CBD programs in Africa. The lessons learned section includes a discussion on why extracting general lessons or universal approaches from the CBD literature is difficult, general conclusions about the management of CBD programs, factors affecting CBD performance as well as quality of care issues.

4.1 Trends in Family Planning Research

Initially, as early as the 1960s, efforts to evaluate family planning focused on clients and potential clients' demand for family planning. Impact was examined and measured in terms of long-term and quantitative program and demographic indicators such as contraceptive prevalence, total fertility, birth rates and couple years of protection (Miller et al, 1991; World Health Organization, 1995; Population Council, 1998). Bertrand et al note that, in the 1970s and early 80s, the bulk of family planning research centered on access, the presumption being that greater access would lead to greater utilization (Bertrand et al, 1995). By the 1980s, the focus of family planning research was switching more to the supply side of services and on the information needed by managers to increase service availability and accessibility (Miller et al, 1991). The need to address quality of care soon followed, primarily as a means to increase contraceptive and continuation rates.

In response to the neglected quality dimension of family planning services, Bruce developed a framework in 1990 to assess six fundamental elements of quality of care. These include choice of methods, information given to clients, technical competence, interpersonal relationships, mechanisms to encourage follow-up and continuity, and an appropriate constellation of services (Bruce, 1990). The Bruce framework, because it efficiently captures the multidimensional nature of quality of care, has been used extensively in family planning investigations since its development (Koenig, 2000; Whittaker et al, 1996; AbouZahr et al, 1996; Miller et al, 1991; Vera, 1993). Other frameworks for understanding the quality of care of family planning have also been proposed in the literature. Although qualitative studies dominate the quality of care literature, researchers have demonstrated that it is also possible to measure quality of services quantitatively, for example, by incorporating quality of care questions into existing demographic surveys (Whittaker et al, 1996; Miller et al, 1991).

The swing of the pendulum from demographic goals and targets to more of a focus on the quality of programs and the reproductive rights of women and men was further strengthened by the 1994 International Conference on Population and Development in Cairo. By identifying family planning information and services as a critical means for the articulation and attainment of reproductive health, the Cairo conference instigated deeper investigation into the quality of family planning care and encouraged a more client-centered approach to service delivery (Hatcher et al, 1997).

While enhancing awareness of how women's lives impact family planning and how family planning impacts women's lives, research focusing on the quality of family planning programs and services have been limited in some aspects. First, frameworks for understanding the quality of family planning programs are most often proposed and applicable for clinic-based services. Indicators of quality and efforts to measure components of quality remain underdeveloped for non-clinical family planning care and community based distribution (Whittaker et al, 1996). Whittaker et al report that "indicators of quality for outreach services have only just begun to be developed, despite this being the main mode of family planning service delivery in many developing countries" (Whittaker et al, 1996, p 395). Second, since attitudes about service quality are more frequently gathered from new or first time service users, continuity of use as a predictor of quality or an indicator of client satisfaction has received much less attention. Finally, an overriding focus on logistical details of family planning services and the technical competence of family planning service providers has often meant that clients perceptions and the experiences that clients themselves bring to the process of preventing pregnancy remain relatively underexplored (AbouZahr et al, 1996; Whittaker et al, 1996). Similarly, little is known about how clients' assessments of quality impact their adoption or continuation of family planning (Whittaker et al, 1996).

AbouZahr et al, in their discussion of global quality health care for women, note that the search for quality of care necessarily comprises a balance between the technical elements of quality and the perspectives and needs of clients (AbouZahr et al, 1996). They advocate that intervention strategies designed to improve program quality and increase client's access to, and use of, health services need to take into account the perspectives of *both* service providers and clients, as well as the constraints they face in providing and receiving services (AbouZahr et al, 1996). A situational analysis which incorporates both program components (such as information, education, communication and logistics) and elements of quality of care provided useful

information about family planning program strengths and weaknesses in Kenya, though its applicability to community based programs has not yet been demonstrated (Miller et al, 1991).

4.2 Lessons Learned from CBD Programs in Africa

Unlike Latin American and Asian countries, which have been experimenting with CBD programs since the 1970s, the strength of CBD effort only began expanding in Africa in the 1980s and 1990s (Phillips et al, 1999; Bertrand et al, 1993). Although coverage within countries is variable and actual rates of exposure to CBD activities are untallied, almost half of the population of sub-Saharan Africa lived in countries exhibiting some CBD effort by 1996 (Phillips et al, 1999). These range from small scale demonstration projects in selected areas to more widespread, systematically organized networks of distributors such as that found in Kenya and Zimbabwe (Phillips et al, 1999; Bertrand et al, 1993).

A 1999 Population Council review of findings and experiences from efforts to implement community based family planning services in sub-Saharan Africa concluded that CBD is administratively feasible in Africa and that it does indeed generate contraceptive use that would not otherwise occur. It also deduces that it is generally more critical to overcome social barriers than geographic barriers to contraceptive access (Phillips et al, 1999). The 1987 Expert Conference on Quality Birth Spacing Services in Francophone Africa concluded, “under certain conditions, CBD is an effective and inexpensive way to increase contraceptive use” (Bertrand et al, 1993, p 84). These “conditions” included training, supervision, remuneration schemes for CBD agents and linkage with health care practitioners in the event of side effects (Bertrand et al, 1993).

4.2.1 The Difficulties in Extracting General Lessons from the CBD Literature

While numerous descriptive studies have examined CBD programs in various countries in Africa, extracting general lessons from the CBD literature is difficult for many reasons. First, Africa’s cultural and ethnic diversity between and within countries often does not allow for such generalizations (Phillips et al, 1999). Second, as discussed earlier, family planning perspectives are not simply a matter of individual preference but are mediated by the unique social, cultural, religious and political environment of the local area where family planning services are experienced. Third, a CBD program’s effectiveness depends on how a number of organizational components (such as training, recruitment and supervision of workers, remuneration, the extent of community involvement, sustainability, cost effectiveness and the link to other health services)

are addressed. Particular management strategies may therefore be successful in some communities and fail dramatically in others.

4.2.2 An Optimal, Universal CBD Approach Does Not Appear To Exist

No single model emerges as the optimal universal approach to CBD and CBD has been found to be effective in a variety of contexts (Phillips et al, 1999). In Kenya, for example, which has a strong national CBD program and is said to have the greatest diversity in CBD programs and activities (and perhaps the highest number of community based distributors) of any country in the world, CBD programs have provider profiles, compensation, recruitment and training schemes and management styles which differ considerably by agency and area.

A variety of CBD approaches are presently being implemented in the developing world. These include door to door services by CBD agents, convenient community distribution and meeting points or depots such as market areas or workplace distribution in which CBD agents visit agricultural gardens, coffee and tea plantations or factories (World Health Organization, 1995). While initially offered mostly in rural areas, CBD programs are increasingly important in urban areas as well (Evans and Huezo, 1997). Though married couples are the traditional service population, CBD workers are also beginning to provide family planning services to youth and unmarried men and women (Finger, 1999b). Agents themselves may be part-time or full-time agents - paid or volunteer. Some sell contraceptives while others distribute them free of charge. The actual service regimens of CBD agents may also vary greatly from one program to another. In Ghana, the Ministry of Health has only recently approved pill distribution by CBD agents (Population Council, 1998). Agents in Zimbabwe not only distribute pills and condoms but also carry stethoscopes and blood pressure machines to assist in screening pill clients (Population Council, 1998). Perhaps as a result of the strong political consensus in favour of integrated reproductive health services (Reproductive Health Outlook, 2000) growing out of the Cairo Conference, some CBD programs are attempting to integrate other reproductive health issues, such as the diagnosis and treatment of sexually transmitted diseases, into family planning distribution. Others, however, continue to focus primarily on contraceptive distribution. The efficacy of integrative efforts is yet to be determined (Mayhew et al, 2000).

It is perhaps this great variation in CBD approaches that has prevented the development of standardized rules on how to effectively implement or manage a CBD program. The basic CBD program component of supervision serves as a good example. While supervision is universally

deemed an essential ingredient and the literature features long lists of supervisory activities considered to be important, there are no clear stipulations on what constitutes adequate supervision. For example, the literature notes that a total lack of supervision is to be avoided but routine as well as unplanned supervision are also deemed likely to be ineffective (Foreit and Foreit, 1984). Clearly, the types and roles of supervisors and the frequency of their visits are most effectively determined by individual CBD program managers who have a keen awareness of local conditions and constraints.

In the initial implementation stage, predetermined CBD strategies may not offer the most appropriate approaches for a particular setting (Phillips et al, 1999). Early CBD experiences in Ghana demonstrate the importance of testing and adjusting CBD strategies to local conditions (Phillips et al, 1999). Organizers, assuming the primary concern of villagers was accessibility, pre-selected midwives and Traditional Birth Attendants (TBAs) as CBD agents since they had proven successful elsewhere. Only upon elicitation of community opinions and local reactions to the failing CBD program was it revealed that, in that particular setting, midwives and TBAs were perceived as being unable to keep secrets and untrustworthy. While TBAs may be effective CBD agents in some areas, they have been found to be more interested in promoting births rather than reducing pregnancies in others. Later CBD initiatives launched in Navrongo, Ghana, concurred that the key to success was designing culturally sensitive approaches for providing information and services to men and women instead of relying on prefabricated strategies (Phillips et al, 1999).

Similarly, uniform evaluation mechanisms will not be effective amidst the rich diversity of CBD approaches. For this reason, studies designed to uncover community perceptions and the factors impeding optimum results of the CBD program in one area must be specifically tailored to the geographic, cultural, social and institutional environment that structures life in the area where outreach services are based (Phillips et al, 1999).

4.2.3 General Conclusions About the Management of CBD Programs

While cross cultural themes and generic lessons about CBD are difficult to derive, research findings allow for general conclusions about elements of basic management that can lead to improvements in service delivery (Phillips et al, 1999). Crucial organizational components that have been identified as instrumental to a CBD program's effectiveness include training, recruitment, supervision of workers and remuneration.

Additionally, a main management theme arising from a review of the literature of CBD in Africa is that community support; participation and involvement are crucial to the success of a CBD family planning program. Involving key individuals from the community – health professionals, educators, political decision makers, traditional and religious leaders as well as potential CBD clients and agents – in both planning and implementation is said to be the most effective strategy for winning community support (World Health Organization, 1995; Population Council, 1998). Additionally, community members' appreciation and acceptance of CBD efforts, like family planning initiatives in general, will likely be enhanced if broad based political support from the highest government levels is apparent and clearly articulated.

4.2.4 Factors Affecting CBD Agent's Performance

While most research has shown that the acceptance of CBD agents is enhanced if they are similar to clients in age, education, sex and life context, research from Kenya illustrates that an agent's age, education level, marital status and religion make little difference to their productivity (Evans and Huezo, 1997; Population Council, 1998). A 1993 study in the Democratic Republic of Congo (formerly Zaire) found that while age of the community based worker was a significant factor, sex, education, marital status and religion were not (Barnett, 1999; Bertrand et al, 1993). Researchers there concluded that CBD workers should be selected primarily on their willingness to participate rather than on social or demographic characteristics (Barnett, 1999; Bertrand et al, 1993).

While many CBD programs in Africa originally recruited female agents only, the demonstrated success of men as CBD agents has led to a concerted effort to recruit males and male – female CBD teams have also been flourishing (Ferguson, 1998; Population Council, 1998). Men may be more difficult to recruit as CBD workers than women, possibly because of other out of home work commitments, but they have proven very effective in reaching other men in both Kenya and Tanzania (Barnett, 1999; Population Council, 1998). In Kenya, contraceptive use and communication between spouses increased when men were included both as clients and workers in CBD programs (Barnett, 1999). While male CBD agents tended to provide more condoms and females more pills, the research could not conclude that one sex was more productive than the other (Barnett, 1999).

Operations research from the Democratic Republic of Congo, one of the first CBD efforts in sub-Saharan Africa, found that, contrary to expectations that a distributor's clientele would increase

over time, the average number of users per CBD worker remained fairly stable. Increases in overall CBD program output, such as couple-months of protection, were obtained by adding more CBD workers to the system and not because of increased performance or outreach by already available CBD workers (Bertrand et al, 1993). This research also concluded that CBD projects and the performance of distributors are vulnerable to political changes such as transfers of medical personnel or pressures from local community leaders (Bertrand et al, 1993). In Tanzania, CBD agents reported that providing a broader range of services made them feel more productive. CBD agents were indeed found to be as much or more productive if they provided other health services as well as family planning (Finger, 1999b). It must be noted, however, that these CBD agents are remunerated and similar studies or findings have not been found with volunteers.

As would be expected, the research record tends to show that paid workers perform better, make more client visits and are more motivated than volunteers (Phillips et al, 1999; Population Council, 1998; Finger, 1999b). However, as was found in Kenya, a higher level of payment does not automatically lead to higher productivity. On the other hand, non-monetary incentives, for example, support for income generating activities of CBD agents, appeared to boost productivity in Tanzania. Completely voluntary schemes do not work very well in the developing world and if workers are not paid, some other motivational scheme is required. Phillips et al write “in the absence of a strong motivational backbone, the viability of volunteer work schemes is doubtful” (Phillips et al, 1999, p 31). In both Kenya and Tanzania, agents in lower contraceptive prevalence areas could be motivated to perform better than those working in areas with higher contraceptive prevalence rate if they received a financial allowance or participated in an income generating activity. The GTZ supported CBD program in Kenya has found a system of incentives, regular rewards and recognition to be effective in ensuring CBD satisfaction and continuation (Ferguson, 1998). It should also be noted, however, that other factors besides remuneration, such as the frequency of supervision and community involvement, have also been found to increase CBD agents’ output in Kenya, Tanzania, Togo and Burkina Faso (Finger, 1999c). The question “what is the best way to motivate workers?”, regardless of the CBD approach utilized, continues to echo throughout the CBD literature.

While CBD models composed of many voluntary agents serving a small number of clients can lead to a good cost effectiveness ratio (Phillips et al, 1999), it cannot be assumed that spending less or nothing on agents necessarily reduces overall program costs. CBD projects relying on volunteers are, in fact, often more complex to manage than programs that rely upon paid agents

and they require more investments in training and supervision (Phillips et al, 1999). In both Tanzania and Kenya, for example, programs that give only non-monetary incentives to their volunteers tend to spend higher proportions of their budget on supervisors, training and administrative costs (Population Council, 1998). Additionally, high attrition levels of volunteers may mean that more program costs must be allocated towards supplementary recruiting and re-training efforts.

4.2.5 Quality of Care Provided by CBD Agents

Largely due to the underdevelopment of quality of care research indicators and approaches for non-clinic family planning services, few assessments of quality of care within CBD projects in Africa have been documented. In one study, which measured quality of care in Kenya and Zimbabwe, CBD agents in Kenya demonstrated disappointingly low levels of technical competence. In both countries, agents were found to discuss a range of methods with their clients but placed more emphasis on use of methods than on establishing clients' needs or discussing side effects and their management (Population Council, 1998). Results from an assessment on a CBD program in Taita Taveta, Kenya, concluded that, because of a strong emphasis on quality of care in all aspects of the program, a core group of satisfied clients can be utilized to encourage other community members to access the project's family planning services (United States Agency for International Development, 1999).

4.3 Conclusion

The above reflection on both the family planning and CBD literature lends support to the need to examine the Kabarole CBD family planning program with a keen appreciation of the interplay of local, contextual factors. Additionally, it calls for the inclusion of multiple elements of investigation (i.e. program components, community challenges and specific elements of quality of care such as technical competence) and multiple views and voices (i.e. clients, service providers and community stakeholders). Ideally, this study will enrich the existing CBD literature by identifying CBD program strengths, weaknesses and challenges and by increasing understanding of the importance of community perspectives on family planning and service delivery.

CHAPTER 5 - STUDY DESIGN

5.1 General Overview of Methodology

Both qualitative and quantitative techniques were employed in this study. Quantitative methods included the administration of two questionnaires, one with active CBD Volunteers and another with active CBD clients. Questionnaires with CBD Volunteers assessed their overall knowledge of family planning and their service delivery approach; their perspectives about the CBD program; as well as the problems faced delivering CBD services. Questionnaires with clients allowed for an assessment of their perceptions of, and levels of satisfaction with, encounters with CBD Volunteers and the CBD program concept in general. Focus group discussions, which have been found to be an ideal tool for both new and established family planning programs in Africa (Baron et al, 1993), were the primary method of collecting qualitative data. Focus group discussions, held with active CBD Volunteers, former CBD Volunteers and adolescents, afforded deeper and sharper insights into community perceptions of family planning in general and the CBD program in particular. Supplementary qualitative data collection methods included key contact interviews, data gathering interviews, a review of CBD records and school presentations to adolescents. These allowed for elaboration and verification of data collected in questionnaires and focus groups discussions. Further specific details about the quantitative and qualitative methodologies are outlined in sections 5.4 and 5.5 of this chapter.

5.2 Setting

The study took place in the district of Kabarole, western Uganda. Specific details about Kabarole, including basic health indicators and the Basic Health Services Project, are outlined in the background sections of chapter three. This particular setting was selected because of previously established professional relationships between the Basic Health Services (BHS) Project and the researcher's thesis supervisor, Dr. Walter Kipp, who served as the Team Leader at BHS from 1988 to 1994.

In collaboration with the BHS reproductive health team, four sub-county sites were selected for this study. Basic criteria for selection included: 1) presence of a functioning CBD program 2) accessibility in the rainy season 3) absence of political insecurity or rebel insurgency and 4) willingness and ability of CBD Trainers and Volunteers to voluntarily participate in the study.

Additional criteria for the selection of study sites included length of time since initial training of CBD Volunteers and a crude superficial assessment of performance of CBD sites. These criteria ensured a mixture of CBD sites (those superficially rated poor, fair or good by BHS staff) and CBD Volunteers (those receiving training as recently as 2000 or as long ago as 1997). Selected study sites were also geographically dispersed throughout the district and included semi-rural and rural areas ranging from 40 to 140 return kilometers from Fort Portal Town. While the four study sites were selected using purposive sampling, BHS staff expressed confidence that the four chosen sites collectively served as a good representation of overall CBD program effort in the district. The selected CBD sites have been indicated on the map in Appendix 3.

Questionnaires with clients and CBD Volunteers as well as focus group discussions with active CBD Volunteers and former CBD Volunteers took place at each of the four sub-county health units. The sub-county health unit serves as a focal point for each sub-county CBD program. The CBD Trainer (group leader or supervisor) is stationed there and CBD Volunteers come from their villages to report to the Trainer and collect additional supplies once a month. Data collection could therefore be organized to coincide with monthly meetings, thereby avoiding unnecessary, extraneous travel by the CBD Volunteers or the research team.

The specific reasons determining the decision to confine data collection to the sub-county health unit instead of attempting to reach CBD Volunteers and clients in their home settings at the parish or village level are described at length in the study limitations section of chapter 9.

5.2.1 Research Team

Indeed, it would have been both impossible and impractical for the researcher to conduct this study independently. Since the study was conducted as participatory research in the form of the organization-development approach, members of the BHS reproductive health team, particularly staff with direct knowledge of the CBD program, participated in various aspects and stages of the study. This included initial topic identification, research design, sampling decisions, interview protocol design, selection of research assistants and the creation of appropriate timetables for field visits. Since most members of the research team were local residents and all spoke the local vernacular, they were able to assist with any logistical, cultural, linguistic or methodological issues arising. They were also invaluable in providing both cultural and linguistic interpretation and an array of undocumented insights into the sociocultural and geopolitical setting of the CBD program.

The research was endorsed and supported by the GTZ Team Leader as well as the District Director of Health Services. The BHS Reproductive Health Advisor provided overall supervision of the research project. The BHS Reproductive Health Coordinator, a female Public Health Nurse responsible for the field coordination of the CBD Program, served as the primary research assistant and was invaluable in providing daily supervision and support both in the office and in the field. Given the Coordinator's in-depth knowledge of the CBD program and her rapport with CBD Volunteers, as well as the lack of availability of experienced and qualified local research assistants in the district, it was mutually determined that her contributions to the study far outweighed any potential, negative influences due to her vested interests as a BHS staff person. It was decided, however, that she would be primarily responsible for client questionnaires and that she would refrain from collecting data from CBD Volunteers because of their knowledge of her in her role as a CBD program coordinator and trainer.

A second male research assistant, who has acquired extensive experience in community health research and holds a Masters in International Development Studies, was hired to assist with the administration of questionnaires and the facilitation, translation and transcription of focus group discussions. Another assistant, a male school teacher with prior experience in quantitative community data collection, was also sporadically hired to assist with the administration of questionnaires to clients and CBD Volunteers. A female secretary employed by the Kabarole District Medical Department was hired to record focus group discussions. The female BHS Adolescent Sexual and Reproductive Health Consultant, responsible for school presentations, provided invaluable research support and assistance on adolescent family planning issues. She also served as the co-facilitator in two focus group discussions with adolescent girls.

All research assistants received comprehensive briefings on the design, purpose and objectives of the study. Appropriate and useful data collection approaches were reviewed with research assistants before each field visit. Debriefings were conducted after each data collection activity. Lessons learned from preceding field visits were shared to maximize productivity and efficiency of upcoming data collection activities. Both individual and group meetings were held continually throughout the data collection process and allowed everyone involved to share personal experiences and viewpoints as well as to discuss problems and themes arising.

Formal training on focus group discussion methodology was deemed unnecessary for the male research assistant responsible for conducting focus groups in the local language since he had

already accumulated about five years experience of qualitative data collection in the district. Notwithstanding, many conversations were held to discuss cultural and pedagogical approaches to focus groups, to share facilitation tips and to attempt to ensure effective and appropriate translation and transcription of focus group proceedings.

5.3 Ethical Considerations

Prior to beginning fieldwork, the study was approved by the Health Research Ethics Board (B: Health Research) at the University of Alberta and the Ugandan Ministry of Health via the Kabarole District Director of Health Services. Upon initial arrival at each CBD health unit site, the researcher, accompanied by the BHS Reproductive Health Coordinator and/or the site CBD Trainer, met with the Clinical Officer in Charge of the health unit and with the Local Council leader for the area. These meetings, while following culturally expected and accepted protocol, provided an opportunity for the researcher to explain the purpose of the investigation and to receive support and approval for the research.

Study participants were assured of confidentiality, privacy and anonymity before participating. Written information letters outlining the purposes and implications of the study, and clarifying that participation was completely voluntary, were provided to participants. A copy of the information letter can be found in Appendix 4. During the pre-testing phase as well as the first day of administering questionnaires, it was observed that many participants, while eager to participate in the study, demonstrated disinterest, indifference and sometimes discomfort in reading the information letter. These reactions may be attributed to varying degrees of literacy in either English, Rutooro or local dialects or a keener cultural appreciation for oral tradition rather than the written word. In light of this observation, all subsequent data collection activities were preceded with an oral group presentation given by one of the key research assistants. The contents of the information letter were articulated, concerns were clarified and participants were requested to give their consent to participate by signing the available consent forms. A copy of the consent form can be found in Appendix 5. As recommended by Smith and Morrow, it was necessary to ask and answer questions and give explanations in ways that were comprehensible in the context of local attitudes and beliefs in the communities (Smith and Morrow, 1996).

Although it was initially assumed that participants, out of fear or suspicion, would not be comfortable or willing to sign consent forms, it was found that all participants were willing to sign once receiving a clear and simple explanation as to why it was important and that

participants would never be quoted by name. Some participants appeared delighted or flattered to sign -- perhaps because they are unaccustomed to having their opinions requested or valued. While the majority of participants were able to sign or print their name on the consent form, some clients used their inked thumbprint to indicate their consent.

5.3.1 Obtaining Consent For Adolescents

Two focus group discussions with school adolescents were arranged via written communication with the Head Master. The letter is included as Appendix 6. Two other focus group discussions, which took place in remote rural schools, were incorporated into the regularly scheduled school visits made by the BHS Adolescent Sexual and Reproductive Health Consultant. All contact with school adolescents was preceded by a formal visit with the school Head Master who received an oral explanation of the reasons and implications of the research. In line with culturally accepted protocol and in light of the logistical complications and practical limitations associated with obtaining parental consent (particularly in boarding schools) for adolescents, the school Head Master provided verbal consent for the participation of students. Students were, however, also provided with a written and oral description of the research and were asked to sign consent forms. Adolescents were informed of their right to refuse participation, regardless of the consent received from the Head Master.

5.4 Quantitative Methodology

Questionnaires were administered to all active CBD Volunteers (N=70, 45 females and 25 males) arriving for their regularly scheduled monthly CBD reporting meeting at each of the four sub-county health units in either October or November. Table 5.1 illustrates the official number of active CBD Volunteers participating and the number of CBD Volunteers completing questionnaires in each of the four CBD sub-county sites.

Table 5.1 **Questionnaire administration in four study sites: year of training; numbers of CBD Volunteers trained, active and participating in questionnaires as well as number of clients participating in questionnaires**

CBD Study Site	Year of Training	No. of CBD Volunteers trained	No. of active CBD Volunteers, as of 09/00	No. of questionnaires with CBD Volunteers	No. of questionnaires with CBD clients
Butiiti	1997	29	28	14	7
Bukuuku	2000	22	22	15	7
Katooke	1999	30	28	22	28
Rwimi	1992 1997	30 32	28	19	7
Total		113	106	70	49

Questionnaires were administered to all clients (N=49, 48 females and 1 male) appearing at the health unit on the specified meeting days. CBD Volunteers were notified by either the CBD Trainer or members of the research team and requested to each invite one of their active CBD clients (someone presently using a family planning method distributed by the CBD Volunteer) to the upcoming CBD monthly meeting. CBD Volunteers were encouraged to invite the client who was scheduled to be, or who would normally be, visited next. They were not told the purpose of the invitation, only that perspectives of clients were being sought and that the time requirement would be minimum. The participation of at least 70 clients, one for every CBD Volunteer attending the meeting, was anticipated. However, only 49 clients attended the meetings. The number of clients administered questionnaires in each of the four study sites is included in Table 5.1. In one study setting, 28 clients came despite an attendance of only 22 CBD Volunteers. Some CBD Volunteers invited clients to the meeting though they were unable to attend themselves. CBD Volunteers in other study sites were unable to recruit clients to attend. They reported various reasons for their female clients' inability to accept the invitation e.g. that women were unwilling or unable to come due to family or work obligations, that some women were shy, suspicious or fearful and that others complained of the time, distance and cost to travel to the health unit. Other CBD Volunteers reported to have garnered their client's commitment to come but on the day of the meeting, these previously consenting clients failed to show up. A few CBD Volunteers also reported that they had never received the notification that it was necessary to invite a client to the meeting.

The rationale for this client sampling and subsequent weaknesses are discussed in detail in the section entitled Study Limitations in Chapter 9.

Questionnaires were interviewer administered. Interviewer and interviewee sat inside the health clinic if space was available and outside if weather permitted but always in privacy, away from other CBD Volunteers, clients or health unit staff. Since English proficiency was not a criterion for participant selection, the researcher was only able to administer questionnaires to CBD Volunteers or clients who were conversant in English. Participants unable to speak English or more comfortable in their own language were administered questionnaires by one of the research assistants.

Interviewee names were never recorded and completed questionnaires were assigned sequential numbers by each interviewer and tallied by the researcher at the end of each data collection day. Client questionnaires included 41 questions and were composed of yes-no or forced choice response categories and a few open-ended questions. Each client questionnaire lasted, on average, 30 minutes. Questionnaires with CBD Volunteers included 38 questions but generally lasted slightly longer, on average 40 minutes, since most CBD Volunteers had many comments to make, particularly in the last open-ended questions assessing their perceptions of the barriers faced in providing CBD services and possible solutions.

At the end of each questionnaire, respondents were thanked for their participation and given a small amount of money (1000 Ugandan shillings, approximately 86 cents CDN) as partial compensation for the transport costs incurred in getting to the health unit.

Copies of the CBD Volunteer questionnaire and the client questionnaire are included in Appendices 7 and 8, respectively.

All data from both the client and CBD Volunteer questionnaires were analyzed with the assistance of the Statistical Package for the Social Sciences (SPSS), version 10 for Windows. Data entry was the sole responsibility of the researcher and was completed before leaving the study setting.

Analysis of quantitative data was primarily descriptive and comparative due to the small number of respondents for both the CBD Volunteer and client questionnaires. Answers to open-ended questions were categorized, coded and entered into the SPSS database, as well as undergoing qualitative content and theme analysis.

In analyzing the CBD questionnaires, each respondent was assigned a knowledge score (out of a possible 20 points) based on the number of correct responses given for five knowledge-based questions (question numbers 17, 19-22). These knowledge scores were then used to test for differences between study groups and relationships with demographic variables or service provision approaches using Pearson Correlation and Independent Samples t-test. By selecting pertinent questions and summing client responses to those questions, scores (out of a possible 5 points) were compiled to assess client satisfaction (question numbers 21, 33-36), client's perceptions of information provided (question numbers 16, 23, 25-27) and clients' family planning knowledge and attitude (question numbers 28-32). Due to the small sample size (only seven clients were available at each of three study sites), statistical tests could not be performed, aside from the non-parametric Kruskal-Wallis test to examine differences in scores between study sites.

5.4.1 Reliability and Validity of Quantitative Data

Building on or replicating measures used in past research increased both the reliability and face validity of the questionnaires (Neuman, 2000, p 168). The majority of questions were derived from previously pre-tested questions utilized in the 1995 Uganda Demographic and Health Survey and previous quality of care family planning assessments from a variety of developing countries including India, Bangladesh, and Chile (Koenig et al, 2000; Koenig and Khan, 1999; Whittaker et al, 1996; Vera, 1993). Many of these studies draw significantly upon the six elements of the quality of care framework that has been used extensively in quality of care family planning research since its development by Bruce in 1990 (Bruce, 1990). Other methods employed to increase the reliability of the questionnaires were 1) clearly conceptualizing constructs such as satisfaction, support, motivation and facilitation and clarifying the specific reasons for the inclusion of questions with research assistants before administering questionnaires and 2) using multiple indicators of a variable (Neuman, 2000, p 166). Client satisfaction, for example, was not measured by simply asking are you satisfied with the program but instead by considering responses to five different indicators or questions which could be examined independently or combined into an overall measure. Similarly, CBD Volunteer

knowledge or technical competence was assessed by using multiple indicators (five questions) of this particular variable. Content validity is also enhanced by this inclusion of a variety of aspects to measure constructs such as satisfaction or knowledge (Neuman, 2000).

Questionnaire reliability was also improved by developing numerous drafts and preliminary versions, as well as by pre-testing which is described below (Neuman, 2000). An extensive list of potential questions and numerous drafts had been compiled and examined by various people, including members of the researcher's supervisory committee, before arrival in Uganda. Upon arrival, and in collaboration with two members of the BHS reproductive health team, further drafts were designed as questions were limited to those deemed of highest relevance by all three reviewers and tailored to ensure socio-cultural and linguistic appropriateness. Program specific questions were included. Questions assessing the knowledge of CBD Volunteers, for example, were based on the local training curriculum as delivered to CBD Volunteers. Other questions were added which allowed BHS staff to acquire information pertinent to their daily management of the CBD program.

Prior to use, questionnaires were pre-tested for clarity and understandability using a small sample of five CBD Volunteers in Kamwenge sub-county, a remote CBD program area not included in the selected study sites. CBD clients were unavailable for pre-testing. However, the client questionnaire was tested on two clinic-based family planning clients in Kamwenge. Since the length of the questionnaire was discovered to be the biggest problem during pre-testing, some less crucial questions were deleted and minor revisions were made to ensure that the questionnaire was long enough to allow for the necessary information to be collected but without unduly inconveniencing the respondents. Since it was obvious from the pre-testing that CBD Volunteers were very eager to converse informally with the interviewers, particularly the foreign researcher, and that clients had specific family planning related questions, it was decided to preface questionnaires with a note that researchers would attempt to make separate time available for non-questionnaire related issues.

Stability reliability, described as reliability across time (Neuman, 2000), was examined by using the test-retest method in which the CBD Volunteer questionnaire was re-administered to two CBD Volunteers two months after they had first completed the questionnaire. 100% agreement was found between the initial and post test responses for categorical, dichotomous variables thereby indicating a high degree of stability reliability. Since different interviewers (of different

sexes) were used in the retest than in the test, intercoder reliability can also be considered high. This also supports BHS staff assumptions and assurances that the sex of the interviewer would not significantly affect responses from CBD Volunteers. However, it must be noted that the proportion of agreement was not as high for continuous variables (such as number of minutes spent counselling a new client or number of hours spent on CBD volunteer work in a week). The proportion of matched versus discrepant responses was calculated for 14 continuous variables for the two individual post tests. Results found a proportion agreement of 50% for one and 57% for the other. While some answers tended to be overestimated in both post tests (e.g. how many hours do you spend doing CBD work in a normal week), an overall, general trend for either overestimation or underestimation was not found. It is possible that CBD Volunteers answered some questions (such as, what is the longest travel time to the client that lives furthest away) differently in the post tests because of changes in their clientele. Additionally, CBD Volunteers may have been more attentive to details of their CBD activities (such as amount of time spent counselling new clients) after they were initially asked and were therefore able to provide more accurate estimations in the post tests. Knowledge scores were higher in both post tests. This could indicate that CBD Volunteers clarified or discussed correct answers after the initial questionnaire and therefore appeared more knowledgeable in the post tests.

Other efforts to ensure validity and reliability of responses included a search for discrepancies between information given by clients and that given by CBD Volunteers on similar issues as well as a content comparison of data from CBD Volunteer questionnaires with data from focus groups and key contact interviews.

5.5 Qualitative Methodology

5.5.1 Focus Group Discussions

The sampling of participants for focus group discussions depended upon the participant's relevance to the research topic as well as situational circumstances presented during the field research (Neuman, 2000). For example, a focus group discussion with active CBD Volunteers was scheduled in one of the four study sites. Sampling was both theoretical and convenient when seven active female CBD Volunteers, who had already completed the questionnaires and were simply waiting to receive family planning supplies from the CBD Trainer, expressed interest and willingness to participate.

Two focus group discussions were also held with eight former CBD Volunteers (program drop-outs) in two different study sites. At one site, the CBD Trainer and the CBD Volunteers had to be relied upon to invite any people they knew in their areas who had received training and worked as CBD Volunteers but had since dropped out of the program. Only three men (between the ages of 40 and 60) were willing and able to accept the invitation. In the other study site, active CBD Volunteers made a list of names of all CBD Volunteer drop-outs in their parishes and villages and each CBD Volunteer took the responsibility of inviting those who lived close to them to the next monthly meeting. In this case, five people, three women and two men all between the ages of 35 and 55, presented themselves at the meeting and all were included in the focus group discussion.

Four focus group discussions were held with in-school adolescents in three separate schools within Kabarole district. Two focus group discussions; one with eight boys (aged 15-18) and one with nine girls (aged 16-20) were held in a semi-rural school located in one of the four study sites. The other two focus groups were held with female adolescents in two rural schools not located within the four original study sites. One of these focus groups involved six females between the ages of 16 and 17 while the other focus group discussion involved six females ranging in age from 14 to 18 years. Since so many students wished to participate in the discussions, students had to be randomly selected using a numbering system whereby all students wishing to participate were assigned a number but only those with the numbers drawn from a hat could participate.

Focus group discussions were carried out in convenient locations offering both privacy and quiet. Sometimes an empty room within a health unit or school was used but focus group discussions primarily took place outdoors in an area shaded or covered by trees.

Interview guides consisting of probe questions were available for all focus group discussions. The interview guides for focus group discussions with CBD Volunteers, former CBD Volunteers and adolescents can be found in Appendices 9, 10 and 11, respectively. A funnel approach to interviewing, with questions moving from the general to the more specific (Rothe, 1994a), was utilized and was particularly effective when talking to adolescents about their family planning service needs.

Focus group discussions with CBD Volunteers and former CBD Volunteers (ranging from 55 to 75 minutes) were carried out in the Rutooro language and were facilitated by the male research assistant with the most extensive training and experience in qualitative data collection available in Fort Portal. The principle researcher, although unable to understand Rutooro, made notes and observations about group dynamics and non-verbal communication patterns during two of these focus groups. At the end of each focus group, respondents were thanked for their participation and CBD Volunteer drop outs were given a small amount of money (1000 Ugandan shillings, approximately 86 cents CDN) as partial compensation for the transport costs incurred in getting to the health unit.

Focus group discussions with adolescents were carried out in English and ranged from 45 to 75 minutes. The male research assistant facilitated the discussion with male students. Focus group discussions with adolescent females were facilitated by the researcher with co-facilitation assistance either provided by the BHS Reproductive Health Coordinator or the Adolescent Sexual and Reproductive Health Consultant. This method of co-facilitation proved quite effective in mitigating any misinterpretations or miscommunication due to slight differences in Canadian and Ugandan English and was particularly useful when students felt more comfortable using Rutooro slang or local expressions or when they were unable to think of the more technical English term. Adolescent focus group participants did not receive financial compensation for their participation but instead were given pens as tokens of appreciation for their time and participation.

Specific characteristics of the focus group discussions are presented in Table 5.2

Table 5.2 **Characteristics of focus group discussions conducted, Kabarole, 2000**

Description	Language	No. of Participants	No. of females	No. of males	No. of minutes
Former CBD Volunteers, Butiiti	Rutooro	5	3	2	95
Former CBD, Volunteers, Rwimi	Rutooro	3	0	3	45
Active CBD Volunteers, Butiiti	Rutooro	7	7	0	90
Adolescents (ages 15-18) Maddox Secondary School	English	8	0	8	90
Adolescents (ages 16-20) Maddox Secondary School	English	9	9	0	70
Adolescents (ages 16-17) Rwamwanja Secondary School	English	6	6	0	45
Adolescents (ages 14-18) Nyabbani Secondary School	English	6	6	0	60
Totals 7		44	31	13	495

Transcription of verbal data from focus group discussions, in conjunction with written notes taking during the sessions, served as the first step in the qualitative data analysis process. An audio tape-recorder with a small, unpretentious microphone attached was used to record all but two focus group discussions. In one case, focus group discussions with boys and girls occurred simultaneously and therefore only one could be taped. In the second case, girls from a very rural school, although initially consenting to the presence of the tape recorder, were too shy and

hesitant to talk when the tape was on so it was removed from the scene. A trained and experienced note-taker was available to keep a written account of the discussions for most of the sessions except the two taking place with females in the rural schools. In these cases, the co-facilitators debriefed the sessions and compiled notes immediately after the discussions.

Recordings of focus group discussions carried out in Rutooro were translated and transcribed directly into English (as recommended by Bertrand et al, 1992) by the facilitator of the discussions. Transcriptions of the recordings of the English focus group discussions were the sole responsibility of the researcher. All written transcriptions, as well as written notes, were entered into Microsoft Word by the researcher while still in Uganda. Since transcriptions provided by the facilitator of the focus group discussions conducted in Rutooro were not as detailed or sophisticated as required for a deep qualitative analysis, these three focus group discussions recordings were re-transcribed upon return to Canada. The recordings were re-translated by a Ugandan student who is acquiring a PhD from the University of Alberta and re-transcribed by the researcher. While no discrepancies were discovered, the re-transcription process provided richer data in the form of verbatim accounts and direct quotations.

Once satisfactory transcriptions of the focus groups were available, a thematic approach to the qualitative analysis of focus groups was used, the general goal being to locate and group together patterns and themes (Rothe, 1994b) of community perceptions of family planning services and specifically, the CBD program. A surface analysis or first round look at the data as a whole (Morse and Field, 1995) was achieved by re-reading the transcripts, reflecting on the data in its entirety, extracting major categories, looking for deviations of the categories as they related to the total design and synthesizing categories to develop themes (Rothe, 1994b). The process of reflection in the examination and coding of data was not underestimated and was facilitated by note taking and diagramming in an effort to obtain a visual representation of common themes and their interactions. A review of the researcher's personal journal, particularly entries immediately following the focus groups, as well as photographs taken during or after focus groups, facilitated this reflection process. Deeper analysis included a search for commonalities (such as those between participants or between groups of participants), divergent or unique perspectives as well as interrelationships between themes (Morse and Field, 1995). Quotes from focus groups were utilized to provide an accurate and realistic portrayal of community perceptions.

5.5.2 Supplementary Qualitative Data Collection

A variety of sources of information were accessed in order to have a more detailed and realistic understanding of the existing standards of care within the CBD program and to complement and verify information gathered during primary data collection.

Upon discovering, during initial discussions with BHS staff, the fundamental role played by CBD Trainers in motivating and organizing CBD efforts, semi-structured interviews (see Appendix 12 for the interview guideline) with each of the four CBD trainers at each study site were added to the data collection plan. Individual interviews with CBD trainers were conducted in English by the researcher. Shorthand notes were taken by the researcher and supplemented with additional notes made immediately after each interview. Three of these interviews took place in a private area of the CBD Trainer's health unit in the sub-counties and one took place at the CBD Trainer's home in Fort Portal. Interviews at the health units were shorter than the one taking place at home, ranging from 30 to 45 minutes, since CBD Trainers were performing their normal nursing clinical duties.

Semi structured interviews (see Appendix 13 for the interview guideline) were also held with either the Local Council (level three) Chairperson or the Sub-County Chief at each of the four study sites. These interviews were prioritized when various CBD stakeholders, including BHS staff, CBD Trainers and CBD Volunteers, articulated that hopes for financial sustainability of the CBD program lay with the increased involvement and ownership of the Local Councils at the sub-county levels. Interviews were scheduled in advance, via CBD Trainers or mail. Often, more than one visit to the sub-county level was needed to find the appropriate person available. Interviews were conducted in English by the researcher alone as the presence of research assistants or BHS staff may have altered the course of the discussion. Two of the interviews were recorded with permission from the leaders while short hand notes were taken for the other two.

The characteristics of the eight key contact interviews are presented in Table 5.3

Table 5.3: Composition of key informant interviews, Kabarole, 2000

Classification of Key Informant	Date	Sex	Duration (minutes)
CBD Trainer, Katooke	October 30	Female	35
CBD Trainer, Butiiti	November 2	Female	35
CBD Trainer, Rwimi	November 6	Female	20
CBD Trainer, Bukuuku	November 22	Female	50
Sub-County Chief Katooke	November 3	Male	45
Local Council 3 Executive Rwimi	November 6	Female	25
Local Council 3 Chairperson Butiiti	November 13	Male	50
Local Council 3 Chairperson Bukuuku	November 16	Male	45

Transcripts and written notes were entered into Microsoft Word by the researcher. Typical of semi-structured interviews, all four CBD Trainers and all four Local Council leaders were asked the same series of questions. The Question Analysis approach, as described by Morse and Field, was therefore used to examine interview data (Morse and Field, 1995, p 141). The initial sorting of both sets of interviews was by question number. For example, all of the responses to question one were first sorted into one category and then read for content. A thematic analysis was then performed to identify themes and sub-themes relating to question one. The same process was followed for the subsequent questions included in the interviews.

Written reports of previous district investigations into family planning, district demographic and data banks, as well as monthly records from CBD sites (particularly the four selected study sites) were also examined to obtain more concrete information on the community challenges to family planning, CBD activities, supervisory and training schedules, client-provider ratios and contraceptive utilization. Field notes and a personal journal, maintained by the researcher to record ideas, reflections, conjectures and interesting comments throughout data collection, were constantly referred to during data analysis and report writing.

5.5.3 Procedures of Verification for Qualitative Data

Important to all qualitative studies are efforts to ensure that the researcher describes reality and social worlds in the same way as they would be described by the study participants (Rothe, 1994b). Authenticity or giving a fair, honest and balanced account of social life from the viewpoint of someone who lives it everyday is perhaps the greatest concern for qualitative researchers (Neuman, 2000). The researcher's decision to re-transcribe focus group discussions rather than make assumptions and estimations of themes is a tangible example of efforts to ensure authenticity. However, being armed with a keen awareness of the political and social context, as well as sensitivities to culture, language, social standing, age, income, education and gender before and during data collection was also crucial to the researcher's ability to capture an accurate, inside view and provide a candid portrayal of those receiving and providing services.

A pilot focus group discussion was held with active CBD Volunteers in one of the study sites. This provided an opportunity for the researcher to have some initial exposure to participants' reactions and behaviours in this cultural setting and to ensure the clarity and appropriateness of guiding questions. More probes, inciting CBD Volunteers to consider quality of care issues as well as program implementation issues, were added as a result. It also served as a reminder that all research assistants, even the inconspicuous note taker, must not be viewed with suspicion by participants. Weeks after this pilot test, participants admitted to their CBD Trainer that they were unable to express their true feelings about support and supervision provided by the health unit since the note taker was an employee of the health unit (though in no way involved with the CBD program). As a result of this articulated limitation, results were not included in the final analysis. However, the pilot focus group offered invaluable lessons for future discussions.

The researcher attempted to ensure interpretative validity, which refers to what the participants really meant when they said or did something, by examining how the meaning of CBD for one participant (or one group of participants) was shared with other participants (Rothe, 1994b). Comparing active CBD Volunteers perceptions of challenges faced in the program to the challenges faced by CBD drop outs many years before, for example, provided an assurance of interpretative validity. The triangulation of methods (or mixing of both qualitative and quantitative styles) (Newman, 2000) provided an excellent opportunity to validate and verify CBD Volunteers' responses on questionnaires and in focus group discussions.

Dependability of data from focus groups and theoretical validity, particularly for formulating recommendations and suggestions for improvement, was solidified by considering a range of data sources and employing multiple methods of inquiry (Neuman, 2000; Morse and Field, 1995; Rothe, 1994b). Semi structured interviews with Local Council leaders, CBD Trainers and other key contacts, for example, confirmed that the problems and potential solutions identified by CBD Volunteers typically reflected those identified by local leaders and health care practitioners. Conversations with more than a dozen school Head Masters, teachers and community adolescent health educators, as well as school presentations in six secondary schools located throughout Kabarole, replicated many of the themes arising from focus group discussions with adolescents.

5.6 Dissemination of Initial Study Results

Before leaving the study site in Uganda, the researcher collaborated with the BHS Reproductive Health Coordinator to identify outstanding areas of weaknesses with regards to CBD Volunteer technical knowledge or approach to clients. Written suggestions for immediate actions that could be taken by CBD Trainers and CBD Volunteers to correct these inadequacies were composed. These suggestions were included in a written report of preliminary study results and disseminated to CBD Trainers and CBD Volunteers who had expressed a keen interest in receiving immediate feedback, particularly regarding questionnaires. Each CBD Trainer was encouraged to devote upcoming CBD Volunteer monthly meetings as opportunities to share the findings and suggestions with CBD Volunteers. A copy of the cover letter to this report forwarded to CBD Trainers can be found in Appendix 14. Feedback in the form of a written package of information was also specifically tailored and forwarded to the “In Charges” at each of the four health units as well as to the Clinical Officers In Charge at the Health Sub District levels. A copy of the cover letter to this report can be found in Appendix 15.

A final oral presentation of preliminary research findings, facilitated by the researcher, was also conducted with BHS staff before leaving Uganda. Over 20 BHS staff, representing various BHS programs including reproductive health, attended. This presentation was utilized as an opportunity to confer and corroborate community perceptions about the CBD program and its future sustainability. Perhaps most importantly, it served as a catalyst for staff to discuss program weaknesses and issues of sustainability in a forthright manner. The enthusiasm perceived and invaluable feedback received demonstrated staff dedication to the CBD program as well as their commitment to initiating CBD program improvements.

CHAPTER 6 - QUANTITATIVE RESULTS

The first section of this chapter (6.1) relays the quantitative results found for questionnaires with CBD Volunteers. Quantitative results for questionnaires with active CBD clients are found in section 6.2.

6.1 Questionnaires with Community Based Distribution (CBD) Volunteers

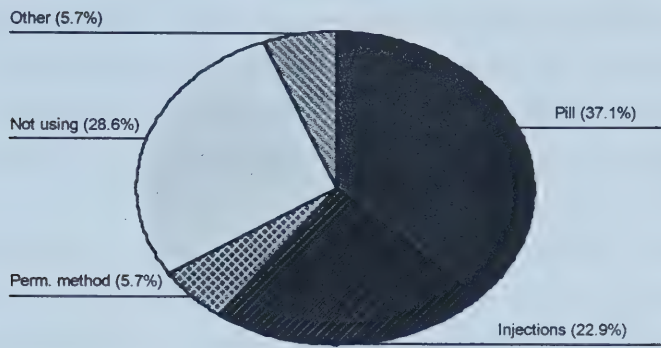
6.1.1 Socio-Demographic Characteristics

Questionnaires (see Appendix 7) were administered to 70 CBD Volunteers in Kabarole district, western Uganda. Questionnaires were administered in the four study sites of Katooke (n = 22), Rwimi (n = 19), Butiiti (n = 14) and Bukuuku (n = 15) in October and November 2000. Forty-five (64.3%) of the CBD Volunteers were female. CBD Volunteer respondents were primarily Catholics and Anglicans (40% and 37.1% respectively, only 4 respondents were Muslim), from the Batooro tribe (68.6%), with an average age of 36 years (SD = 10.08). The majority of CBD Volunteers were married (74.3%) and over half of these were reported to be monogamous relationships (58.6%). Ninety per cent of respondents had either primary (n = 27) or lower secondary (n = 36) education*. CBD Volunteers were primarily small-scale farmers or cultivators (44.3%), involved in small-scale businesses and sales of local agricultural products (21.4%) or some combination of both (20%).

CBD Volunteers had an average of five children. 70% reported to be using family planning, primarily oral contraceptives (37.1%) and injections (22.9%). (See pie chart in figure 6.1.) Those who were not using family planning cited advanced age or lack of sexual relationships as reasons.

* Primary (P) education includes P1 to P7 and is roughly equivalent to the combination of primary and elementary schooling (grades 1 to 6) in Canada. Lower secondary (S) includes S1 to S4 and is roughly equivalent to junior high (grades 7 to 9) in Canada. Ugandan students earn their High School Certificate after completing two years (S5 and S6) of Upper Secondary School.

Figure 6.1 Pie chart of contraceptive methods used by CBD Volunteers



“Other” denotes 1 no answer, 1 condom user and 2 reports of abstinence

6.1.2 CBD Volunteers’ Technical Competence

CBD Volunteers were asked a series of questions about their first visits with a client who has expressed interest in beginning to use CBD family planning services. They reported that, on average, 60 minutes were spent counselling a new client. This time ranged from ten to 360 minutes and CBD Volunteers often mentioned that multiple visits were required before a client agreed to begin using contraceptives. When asked which family planning methods they discuss with new clients, 100% mentioned pills, 88.6% mentioned condoms and 80% mentioned foam tablets - the three methods provided by CBD Volunteers. CBD Volunteers also reported to tell clients about methods not provided by the CBD program. 85.7% reported to tell clients about injections and more than 60% also mentioned that they tell new clients about Norplant, Intrauterine Devices (IUDs) and permanent methods such as sterilization. CBD Volunteers reported to tell clients about an average of six methods (SD = 1.53), this ranged from two to nine methods. 78.9% listed five or more methods that they reportedly discuss with new clients.

During training, CBD Volunteers are given a checklist (in both English and Rutooro) of approximately eight pertinent issues that should be discussed with clients before contraceptives are distributed. When asked about this, CBD Volunteers mentioned discussing an average of four

of the eight issues with clients. 85.7% said they tell clients how to use the contraceptive and 71.4% reported to ask clients about their health status. However, only 65.7% mentioned that they talk to clients about possible side effects and 62.9% tell clients how the method works in the body to prevent pregnancy. Only 38.6% said that they ask clients about their reproductive health goals (e.g. do you want more children?), only 30% asked clients about their past experience with family planning and 35.7% mentioned the importance of arranging future follow-up with clients. 22.9% said they question clients about their husband's knowledge or approval of family planning use.

When asked what they tell new clients in order to ensure correct condom use, 87% of the CBD Volunteers gave correct and comprehensive instructions, listing at least four of the five important points that had been included in their training. The instruction least mentioned (missed by 41.4%) was the need to tell clients to check the expiry date and examine the package for damage.

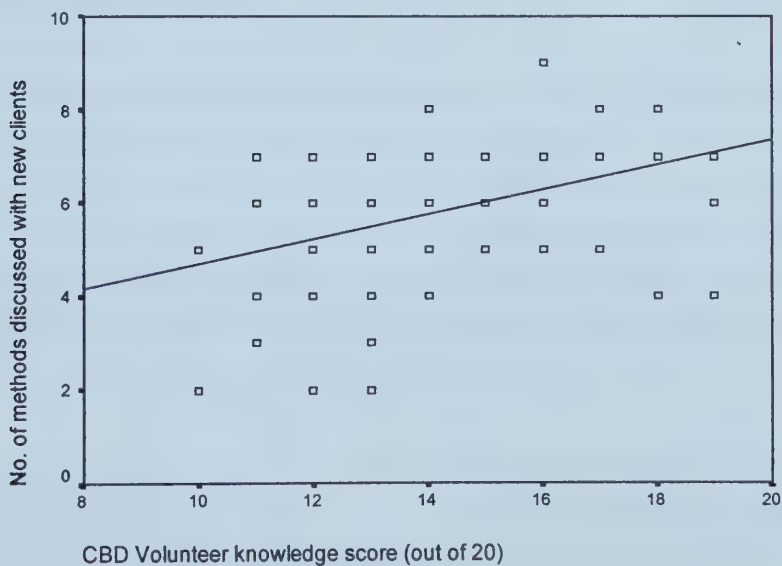
Three questions regarding oral contraceptives, once again based on training curriculum content, were included in the questionnaire. When asked about the best possible time for a woman to begin using the pill, 64.3% of CBD Volunteers gave the best possible answer (during her menstrual period) and 32.9% said she could start right after her period had ended. Eighty-nine per cent of CBD respondents agreed that adolescents could use oral contraceptives. During their training, CBD Volunteers are discouraged from providing contraceptive pills to women with heart problems, high blood pressure or tuberculosis and are asked to instead refer these women to the health unit. Although the majority (over 70%) agreed that they should not provide pills to these women, approximately 20% expressed confusion that women with heart problems, high blood pressure or tuberculosis could take "special" contraceptive pills, "special" connoting POPs (progestin-only pills) vs. COCs (combined oral pills). When asked what they would tell a client who complains of headaches and nausea after using the pill for two months, 75.7% correctly stated they would either encourage clients to persist as symptoms generally become less or stop within three months or refer the client to a health worker.

A knowledge or technical competence score was assigned to each respondent based on the number of correct responses given for the five knowledge-based questions discussed above (important issues to discuss with new clients, ensuring correct condom use, best time to begin using a new method, women who cannot use the pill and responding to side effects). Scores, out of a possible 20 points, ranged from 10 to 19 with an average score of 14.41 (SD = 2.31).

No significant difference in knowledge score was found between the four study sites. Similarly, no significant relationships were found between knowledge scores and demographic data such as age, marital status, occupation or sex. The mean knowledge score was found to be the same for CBD Volunteers with a primary education or lower secondary education (Mean = 14.47) as those with upper secondary or post secondary education (Mean = 14.41). Also, no relationship was found between knowledge score and having clients under the age of 18.

However, it was found that, as the number of family planning methods reportedly discussed with new clients increases, the knowledge score also increases ($r = 0.398$, $n = 70$, $p = .001$, two-tailed)*. See the scatterplot found in Figure 6.2. Additionally, CBD Volunteers who report to discuss side effects with clients had a higher knowledge score (Mean = 15.04, SD = 2.39) than those that did not discuss side effects (Mean = 13.21, SD = 1.56). This difference was significant, $t(64.5) = 3.86$, $p < .001$, two-tailed.**

Figure 6.2 Scatterplot of number of family planning methods reportedly discussed with new clients with CBD Volunteer knowledge score



* Pearson Correlation

** Independent Samples T-Test

6.1.3 CBD Volunteer – Client Interaction

Forty-seven per cent of CBD Volunteers stated it was they who decided on the time and place of meetings with clients, only 17.1% said that it is the client who decides. Exactly half of CBD Volunteers said they have clients under the age of 18. Of those who said they do not have adolescent clients, 30% said the reason was that youth are shy or fearful. 78.6% of CBD Volunteers said they have female clients who are using family planning in secret from their husbands. 87% said their clients generally comply when they refer them to another health worker. Only five CBD Volunteers said they had never yet referred a client elsewhere for services. 80% said that clients do not offer anything (money or in-kind contributions) for their CBD services.

6.1.4 CBD Volunteer Activities and Perspectives on Program Implementation

35.7% reported to deliver other health services besides family planning including Tuberculosis drugs (Direct Observed Therapy), immunizations and anti-malarials (chloroquine). Two CBD Volunteers also served as Traditional Birth Attendants in their villages. More than 95% reported to talk to clients about other health issues besides family planning such as nutrition, breastfeeding, immunization, hygiene and sanitation. These issues are not, however, included in the training curriculum of CBD Volunteers.

CBD Volunteers had been participating in the CBD program for a wide range of time, from one to 96 months. The median number of months was twelve. The number of hours spent every week on CBD activities, including travel time, also varied greatly from one hour to 48 hours, with a median number of eight and a half hours per week. When asked about the travel time, walking one way, to reach the client who lives furthest away, CBD Volunteers reported a median of 60 minutes. They also reported a median of 90 minutes to walk to the sub-county health unit in order to attend their monthly reporting meeting or replenish supplies.

More than half (52.9%) reported no problems receiving supplies of contraceptives in the last six months although 32.9% reported some problems, primarily the lack of availability of certain types or brand names of oral contraceptives. 81.4% felt they need to receive more support (for example, more visits, supervision, guidance, assistance) from the CBD Trainer in order to do a better job as a CBD Volunteer. Although 64.3% said the training received was enough for them to do a good job, 94.3% said they would like to receive more training, primarily refresher courses and updates (45.6%) but also in how to give injections (40%). 22.9% also stated their desire to receive training in community health issues besides family planning such as tuberculosis, malaria, midwifery.

85.7% said they do not have enough information, education and communication (IEC) materials to do their work as CBD Volunteers and the majority (77.1%) requested to have more posters, flipcharts, textbooks, pictures or visual aids.

6.1.5 CBD Satisfaction

Only one out of 70 CBD Volunteers responded that she did not plan to remain active as a CBD in the next one year. 100% agreed that their work as a CBD Volunteer is making a positive change to the health of families in their parishes. When asked how being a CBD Volunteer had changed or impacted their lives, 67.1% of respondents mentioned increased popularity, prestige, recognition or respect. 44.3% mentioned increased personal knowledge and skills, 42.9% referred to increased personal well-being, self-esteem and autonomy issues and 35.7% cited improved health or wealth of their own families.

6.1.6 CBD Volunteers' Perceptions of Problems and Solutions

In response to the question who or what prevents people from using and continuing to use family planning in their parishes, 88.7% of CBD Volunteers stated religious leaders or religion, 71.8% said that men and/or husbands impede family planning use, 63.4% attributed lack of use to rumours, gossip and misconceptions, 32.4% mentioned fear of side effects, 29.6% said ignorance and illiteracy, 16.9% attributed it to desire for more children and 15.5% said cultural or traditional beliefs.

Respondents were asked to describe the main problems they face in their work as CBD Volunteers. 95.7% mentioned transport issues, 92.9% mentioned lack of allowances or financial remuneration, 52.9% said lack of protective wear such as umbrellas, gumboots and rain-jackets. Over 20% also mentioned lack of uniforms as well as problems related to lack of community support.

When asked for their suggestions on how to solve these problems, 88.6% stated that a travel allowance should be made available, 77.1% mentioned the need for bicycles, over 70% mentioned the provision of allowances or financial incentives and lunch allowances. 60% said that protective wear should be provided by the program and 27.1% wished to be provided with uniforms. 60% stated they wanted more support and supervision from the health unit or program managers and 44.3% said that men, the community or religious leaders needed further

sensitization about family planning. 22.9% mentioned wanting more support for their CBD income generating activities.

6.2 Questionnaires with CBD Clients

6.2.1 Socio-Demographic Characteristics

Questionnaires (see Appendix 8) were administered to 49 active clients in each of the four study sites, Katooke (n = 28), Butiiti (n = 7), Bukuuku (n = 7) and Rwimi (n = 7) in October and November 2000. The majority of respondents (75.5%) were from the Batooro tribe, 44.9% were Catholic and 32.7% were Anglican (only 4 respondents were Muslim). Please see table 6.1 to compare these characteristics for both clients and CBD Volunteers.

Table 6.1: Numbers of respondents at each study site and sex, tribe and religion of CBD Volunteers and clients, Kabarole, 2000

Variable	CBD Volunteers		Clients	
	N	(%)	N	(%)
Study Sites				
Katooke	22	(31.4%)	28	(57.1%)
Rwimi	19	(27.1%)	7	(14.3%)
Bukuuku	15	(21.4%)	7	(14.3%)
Butiiti	14	(20.0%)	7	(14.3%)
Sex				
Female	45	(64.3%)	48	(98%)
Male	25	(35.7%)	1	(2.0%)
Tribe				
Mutooro*	48	(68.6%)	37	(75.5%)
Other	12	(17.1%)	8	(16.3%)
Mukiga	9	(12.9%)	4	(8.2%)
Missing	1	(1.4%)		
Religion				
Catholic	28	(40.0%)	22	(44.9%)
Anglican	26	(37.1%)	16	(32.7%)
Other	12	(17.1%)	7	(14.3%)
Muslim	4	(5.7%)	4	(8.2%)

* Mutooro is the singular form of Batooro, i.e. one individual from the Batooro tribe.

Forty-eight of the 49 active clients interviewed were female. Ages ranged from 18 to 48 years with a median age of 26. The majority (65.3%) reported having received a primary education (though 24.5 % reported no schooling at all) and to work as subsistence farmers (69.4%).

79.6% were married with 59.2 % of those married reporting to be in a monogamous marriage. 22.4% reported that their marriage was polygamous*, nine married respondents did not indicate if the relationship was monogamous or polygamous which may be an indication of the presence of multiple but less official wives.

These socio-demographic characteristics of CBD Volunteers and CBD clients are presented in Table 6.2.

* Data collection did not include inquiry into whether or not polygamy indicated official or non-official (informal) wives nor the number of other wives.

Table 6.2 **Socio-demographic characteristics of CBD Volunteers and clients, Kabarole, 2000**

Variable	CBD Volunteers		Clients	
	N	(%)	N	(%)
Marital Status				
Married	52	(74.3%)	39	(79.6%)
Single	14	(20.0%)	6	(12.2%)
Widowed	3	(4.3%)	1	(2.0%)
Divorced / separated	1	(1.4%)	3	(6.1%)
Marriage type				
Monogamous	41	(58.6%)	29	(59.2%)
Polygamous	12	(17.1%)	11	(22.4%)
Missing	1	(1.4 %)	0	
Education				
None	0		12	(24.5%)
Primary (P1-P7)	27	(38.6%)	32	(65.3%)
Lower Secondary (S1-S4)	36	(51.4%)	3	(6.1%)
Upper Secondary (S5-6)	3	(4.3%)	0	
Post secondary	4	(5.7%)	2	(4.1%)
Occupation				
Cultivation	31	(44.3%)	34	(69.4%)
Business/service	15	(21.4%)	10	(20.4%)
Combination of above	14	(20.0%)		
Other	8	(11.4%)	5	(10.2 %)
Unemployed	1	(1.4%)		
No answer	1	(1.4%)		
Age				
Mean (SD)	36.14	(10.08)	26.75	(6.97)
Range	20 - 62		18 - 48	
Number of children				
Mean (SD)	5	(3.02)	4.18	(2.46)
Range	0 – 13		0 - 10	

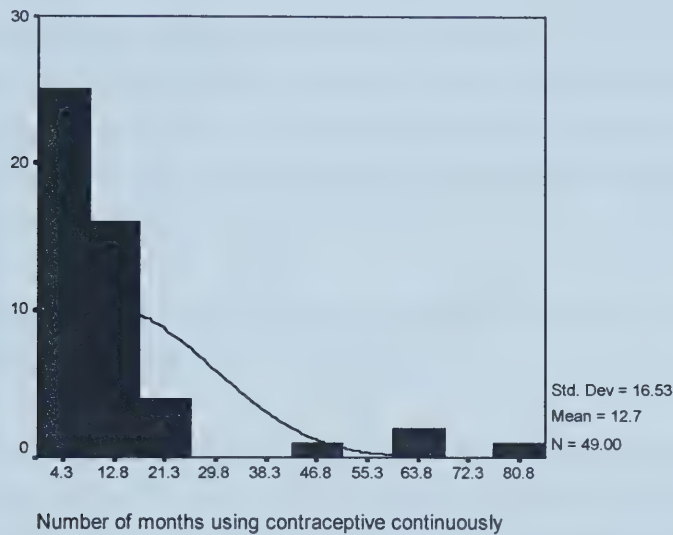
6.2.2 Family Planning Use

Clients had an average of 4 children, 44.8% had between five and ten children. 46.9 % said they did not want to have any more children. 51% said they wanted one, two or three more children.

The majority of respondents (47/49) reported using pills, only one person was using foam tablets and the only male client was the only respondent reporting condom usage. Respondents had been

using their method for a wide range of months, from two to 84. The median number of months of continuous use was eight. 81.3% had been using their method for one year or less. 85.7% of clients reported that their spouses were aware of their family planning use. Figure 6.3 illustrates the distribution of the number of months of continuous contraceptive use reported by clients.

Figure 6.3 **Histogram of number of months of continuous contraceptive use, as reported by CBD clients in Kabarole, 2000**



65.3% reported to experience (or have experienced) problems or side effects with their family planning method. 49% said they received help or advice from the CBD Volunteer on how to deal with these side effects and 10% said they had not contacted the CBD Volunteer about the problems. 79.6% reported to know when they had to next visit with their CBD Volunteer in order to receive more supplies, 20.4% did not know or did not answer.

6.2.3 Client – CBD Volunteer Interaction

71.4% reported that they first found out about the availability of the CBD program from the CBD Volunteer. Only 3 of the 49 respondents reported having experienced any problems accessing the CBD Volunteer or receiving contraceptive supplies in the last six months.

When asked who usually decides on the time and place of meetings between clients and CBD Volunteers, 30.6% said that they, the clients, decide. 24.5% said the CBD Volunteer decides and 42.9% said that the client and the CBD Volunteer decide together. When asked if they give the

CBD any payment (money or in-kind) for their services, 77.6% said no. Of those who said they did not pay the CBD, 67.3% said they would be willing to pay for CBD services if requested to do so. 10.2% said they would not be willing or able to pay.

Responses from both clients and CBD Volunteers for a variety of family planning use and interaction questions can be compared in Table 6.3.

6.2.4 Assessing Clients' Perceptions of Information Provided

Five questions were posed to assess client's perceptions of the information provided to them by CBD Volunteers. Clients reported that CBD Volunteers told them about an average of four different family planning methods. 79.5% reported that they had been told about between three and six different types of methods.

The types of methods discussed by CBD Volunteers, as reported by both CBD Volunteers and clients, are also illustrated in Table 6.3.

When asked if the CBD Volunteer provided them with information about the possible side effects of the family planning method they are using, 91.8 responded affirmatively. 100% of respondents said that, when the CBD Volunteer explains something to clients, she/he uses words and ideas that are clear and easy to understand. 24.5% reported that the CBD Volunteer had not talked to them about sexually transmitted diseases, including HIV/AIDS. More than 75% said that they normally or generally talk about other health topics such as nutrition, hygiene and sanitation, breastfeeding and immunization with their CBD Volunteer.

Each client was assigned an information provided score based on their responses to the five questions discussed above. Scores ranged from one to five (out of a possible range of zero to five points) with an average score of 4.49. The mean scores did not differ significantly* between study sites: Katooke (4.68), Bukuuku (4.43), Butiiti (4.14) and Rwimi (4.14).

* Tested using the Non-parametric Kruskal-Wallis Test

Table 6.3: Family planning related variables, responses from both CBD Volunteers and clients

Variable	CBD Volunteers		Clients	
	N	(%)	N	(%)
Using family planning?				
Yes	49	(70.0%)	49	(100%)
No	21	(30.0%)	0	
Which method?				
Pill	26	(37.1%)	7	(95.9%)
Not using	21	(30.0%)		
Injections	16	(22.9%)		
Permanent methods	4	(5.7%)		
Condoms	1	(1.4%)	1	(2.0%)
Abstinence	2	(2.9%)		
Foam tablets	0		1	(2.0%)
Methods reportedly discussed by CBD Volunteers (multiple responses possible)				
Pill	47	(95.9%)	70	(100%)
Injection	42	(85.7%)	60	(85.7%)
Condom	37	(75.5%)	62	(88.6%)
Foam Tablets	34	(69.4%)	56	(80.0%)
IUD	16	(32.7%)	43	(61.4%)
Permanent methods	16	(32.7%)	48	(68.6%)
Norplant	13	(26.5%)	42	(60.0%)
Other methods (e.g. abstinence)	1	(2.0%)	26	(37.1%)
Who decides on the time and place of CBD-client meetings?				
CBD and client together	5	(35.7%)	21	(42.9%)
CBD Volunteer	3	(47.1%)	12	(24.5%)
Client	2	(17.1%)	15	(30.6%)
Do you receive/provide payment for CBD services?				
No	56	(80.0%)	38	(77.6%)
Yes	6	(8.6%)	10	(20.4%)
Some yes, some no	6	(8.5%)	1	(2.0%)
In kind	2	(2.9%)		
No. of methods discussed				
Mean (SD)	5.86	(1.53)	4.20	(1.58)
Range	2 – 9		0 – 7	

6.2.5 Assessing Clients’ Knowledge and Attitudes About Family Planning

85.7% of respondents gave the correct answer when asked if their family planning method was effective in preventing sexually transmitted diseases (STDs) or HIV/AIDS. However, 10.2% gave the wrong answer, that is, said their method was effective in preventing STDs when it is not and a further two respondents did not know. 93.9% answered correctly that it is possible for a person to have an STD or HIV and still look healthy. Nobody said that contraceptives were more dangerous than giving birth but four per cent did not know or were not sure. Eight out of 49 respondents thought that family planning methods could make a woman weak or decrease her health, three others did not know. 28.6 % thought adolescents in Kabarole should not use family planning.

Each client was assigned a knowledge/attitude score based on their responses to the five questions discussed above. Scores ranged from three to five (out of a possible range of zero to five points) with an average score of 4.27. The mean scores did not vary significantly* between study sites: Butiiti (4.57), Katooke (4.29), Bukuuku (4.14) and Rwimi (4.00).

6.2.6 Client Satisfaction with CBD Services

Five questions were posed to ascertain client satisfaction. When asked if they plan to continue using their method for the next one year, 91.8% said yes. Only eight of the 49 respondents expressed concern or worry that the CBD Volunteer would tell others that they are using family planning. 81.6% of respondents reported having recommended the CBD services to a friend, relative or other. When asked if overall, they were satisfied with the services provided by the CBD Volunteer, 95.9% said yes. Clients were also asked if, given other opportunities or possibilities, they would prefer to go somewhere else for family planning services other than the CBD Volunteer. 98% said no. Respondents offered a variety of reasons for not wanting to go elsewhere and these have been compiled in the Table 6.4.

Each client was assigned a satisfaction score based on their responses to the five questions discussed above. Scores ranged from three to five (out of a possible zero to five points) with an average score of 4.49. Mean scores did not vary significantly* between study sites: Katooke (4.57), Bukuuku (4.43), Rwimi (4.43) and Butiiti (4.29).

* Tested using the Non-parametric Kruskal-Wallis Test

Table 6.4: **Clients’ reasons for not wanting to go elsewhere for family planning services**

Reasons for not wanting to go elsewhere for services	Number	%
CBD program is more accessible, CBD Volunteer is available	30	61.2
Good education, counselling, advice and information provided	12	24.5
Like the continuity offered by the CBD program	9	18.4
Same or better quality than at other places	6	12.3
Good interpersonal relations with CBD Volunteer (e.g. she treats me well, she is nice to me)	4	8.2
CBD service is free	3	6.1
Privacy and confidentiality	1	2.0

Clients were also asked to describe what they like best or most about the CBD program. Multiple responses included CBD is accessible (“near me”) and available; the ability to space, limit and plan pregnancies; the good education, counselling, advice and information provided; free services; better personal and children’s health; better community health and awareness; good quality services and increased family income. These responses are found in Table 6.5.

Table 6.5 What clients say they like best about the CBD program

Like best that / the...	Number	%
CBD Volunteer is accessible (“near me”) and available	31	63.3
Ability to space, limit and plan pregnancies	23	46.9
Good education, counselling, advice and information provided	16	32.7
Services are free	11	22.4
Better personal and children’s health	11	22.4
Good quality services	10	20.4
Better family/community health and awareness	8	16.3
Increased family income	4	8.2
Privacy	3	6.1

6.2.7 Client Perceptions of Problems and Solutions

Clients were asked the question, who or what prevents people from using and continuing to use family planning in your parish? 55.1% said husbands, 46.9% said rumours, gossip or misconceptions, 34.7% said fear of side effects, 22.4% said desire for more children, 20.4% mentioned ignorance, lack of awareness of the benefits of family planning or illiteracy, 10.2% said religion or religious leaders and 6.1% mentioned cultural or traditional beliefs.

Clients and CBD Volunteers perspectives about what prevents people in their villages from using family planning are presented in Table 6.6.

Table 6.6 CBD Volunteers’ and clients’ perspectives on what prevents people from using family planning in their villages

Reasons Offered	CBD Volunteers		Clients	
	N	(%)	N	(%)
Religion or religious leaders	63	88.7	5	10.2
Men or husbands	51	71.8	27	55.1
Rumours, gossip and misconceptions	45	63.4	23	46.9
Fear of side effects	23	32.4	17	34.7
Ignorance and illiteracy	21	29.6	10	20.4
Desire for more children	12	16.9	11	22.4
Cultural or traditional beliefs	11	15.5	3	6.1

Clients were given the opportunity to discuss the main problems they face in receiving family planning services via the CBD program. The majority of clients said they did not face any problems or did not list any problems. Very few offered possible solutions or ideas when asked how, in their opinion, could the CBD program be improved. The main suggestion offered by 17 respondents (34.7%) on how the program can be improved was to increase community education and sensitization, especially for men and religious leaders. Three people mentioned the need to train more CBD Volunteers, four mentioned that the program should make all efforts to ensure there is a regular supply of contraceptives, four said there was a need to train CBD Volunteers in more health areas, especially on how to give injections and four respondents also mentioned that CBD Volunteers should be given money, allowances or transport.

CHAPTER 7 – QUALITATIVE RESULTS

While quantitative findings provided a valuable, basic foundation of information about the local CBD context, qualitative results allowed for a more comprehensive understanding of the issues at play. Qualitative results were used to identify community perceptions of problems and solutions related to providing family planning services in Kabarole. They also allowed an exploration of the perspectives of adults and adolescents on the involvement of adolescents in the program and provided cultural context to the findings.

Discussion guides and emerging themes were comparable for both focus groups and key informant interviews with CBD Volunteers, former CBD Volunteers (i.e. CBD Volunteer drop-outs), CBD Trainers (i.e. group leaders) and Local Council (LC) community representatives. These results are discussed collectively in the first section of this chapter (7.1). Discussions with adolescents involved slightly different objectives and directions and are therefore discussed separately in section 7.2.

7.1 Community Perceptions on Family Planning and the CBD Program

The content analysis of focus groups with CBD Volunteers and former CBD Volunteers as well as key informant interviews with CBD Trainers and Local Council (LC) representatives focused on five major pre-selected areas: perspectives on the benefits of family planning and the CBD program including the efforts of CBD Volunteers, perceptions of community challenges to providing family planning in the district, perspectives on program-related problems faced by CBD Volunteers and suggestions on how to meet both community and program-related challenges. Each area revealed major themes and sub-themes. These are summarized in table 7.1.

Table 7.1 Table of the major themes and sub-themes relating to community perceptions on family planning and the CBD program

Community Perceptions on Family Planning and the CBD Program
<p>The Benefits of Family Planning and the CBD Program</p> <ul style="list-style-type: none">• <i>Increased family planning awareness is making positive changes in the community</i>• <i>Increased family planning acceptance is having a direct impact on women’s lives</i>• <i>Despite the positive changes, there is still more work to do</i>
<p>Community Challenges to Family Planning</p> <ul style="list-style-type: none">• <i>Male opposition and spousal disagreement about family planning</i>• <i>Religious opposition</i>• <i>Fear, ignorance and misconceptions in the community</i>
<p>Community Perspectives on CBD Program Related Problems</p> <ul style="list-style-type: none">• <i>Not even a bar of soap</i>• <i>It’s like chasing the sun</i>• <i>You cannot train someone and then just dump her there</i>• <i>We are frustrated but committed</i>
<p>Perspectives on how to Increase Family Planning and CBD Acceptance</p> <ul style="list-style-type: none">• <i>Increase community education, awareness and sensitization activities</i>
<p>Suggested Solutions For Meeting CBD Program Related Challenges</p> <ul style="list-style-type: none">• <i>Incentive schemes</i>• <i>Enhance support from above</i>

7.1.1 The Benefits of Family Planning and the CBD Program

Increased family planning awareness is making positive changes in the community

At some point in interviews and focus groups, participants expressed satisfaction and pride that family planning awareness, acceptance and utilization had increased in their villages. Whether probed or not about the benefits of family planning, participants eagerly indicated that, despite the challenges and limitations, positive change had already taken place and a marked difference could be seen, particularly with regards to people’s increased access to information and services.

“People are now realizing the need for family planning. They have been informed, now they ask questions, this is why...the youth they are using condoms, the women are using pills. People have adapted the information, they go for help and they know it is useful.”
(Local Council Leader)

There was widespread agreement that the community activities and accessibility of CBD

Volunteers were key contributors to the increased acceptance of family planning, particularly to those people living in more geographically isolated areas.

“In the past we left the family planning work to the health unit but today the CBD Volunteers are reaching far corners of the sub-county. They are creating awareness in the community. They are selling our ideas to almost every corner. And also because they are supplying materials, not just information. And the people, they are accepting.” (Local Council Leader)

Besides CBD Volunteer efforts, socioeconomic factors were also mentioned as contributing to the increased acceptance of family planning. Local leaders, in particular, were likely to point out that economic, environmental and political pressures were forcing people to realize the importance of family planning. Poverty, land shortages, lack of basic essentials such as firewood and water, and legislative pressure from district and national government bodies were often cited as reasons for people's increased acceptance and interest in family planning.

“In the beginning family planning was not liked but now because of the economic factors everyone is going for family planning. In general the attitude is very encouraging. Even the economic situation, as bad as it is, it helps the cause of family planning. Even government is saying that children have to go to school with the new UPE (Universal Primary Education Program), that every child has to have food. If you have too many children you have many problems. We tell people produce less and maintain them or the government will force you to maintain them. Because of government and UPE even the children will claim their rights so parents have to maintain them. People are realizing they should only have a number of children who they can manage.” (Local Council Leader)

Children were frequently mentioned as direct benefactors of the improved acceptance and availability of family planning. When asked how family planning had improved the situation in their villages, the majority of respondents noted that family's abilities to space and limit children allowed them to provide better care for existing children.

“Now more people have welcomed the program. At first they were scared but now people can see the difference, the benefits. Now, they space children. Now they can clothe them, feed them but when they have many they fail to feed them, clothe them, send them to school, they cannot manage to feed them, they get sick, they get malnutrition etc.” (Local Council Leader)

Parent's capacity to pay obligatory secondary school fees, which have only recently been introduced alongside Universal Primary Education in Uganda, appeared to be high priorities for childcare and maintenance.

"But now people have come to realize that, say if you have more than five children you cannot support them, for example education, school fees for so many, it is not possible but also feeding them, dressing them, you cannot, so you have to be able to plan the family." (Local Council Leader)

"Kids have been able to go to school, fewer children equals fewer school fees, children have more, their quality of life has improved, they have food to eat in their homes." (CBD Volunteer, female)

Although most respondents agreed that adolescents now know more about sexuality and reproductive health issues than years ago, they did not appear to view adolescents as direct benefactors of family planning services. Most discussions about adolescent access to family planning and their access to the CBD program in particular were not spontaneous, but required direct probing. For some respondents, particularly CBD Trainers and Volunteers, this appeared to be due to an assumption that married women, not adolescents, are the primary target clients of CBD Volunteers. Other respondents were reluctant or unable to take a clear stand regarding adolescents and family planning. While agreeing that adolescents lacked appropriate information and services, they also referred to the community perception that increasing adolescent education and access to family planning was synonymous to encouraging promiscuity and immorality.

The consequences of adolescent pregnancy, though rarely discussed, focused primarily on the need for female students to abandon their studies when they become pregnant and on the unwillingness of young males to take responsibility for their sexual behaviour. These issues appeared to be discussed in a tone of resignation or acceptance of the status quo. As one local leader surmised, *"this is the way things are here"*. Suggestions for changing predominant cultural attitudes or institutional policies (e.g. school regulations declaring the immediate dismissal of pregnant female students) were not articulated by participants. Only a few respondents, primarily limited to the one study site of Bukuuku, were optimistic that the family planning awareness and education of adolescents had increased as a result of the CBD program. It should be noted that this particular CBD program is exemplary in its efforts to reach adolescents and in its distribution of condoms to unmarried men. This CBD program is also one of the few CBD programs in the district that has established a strong collaboration with a national foreign-funded initiative for adolescents known as PEARL (Program for Enhancing Adolescent Reproductive Life).

“More people are using family planning. We (CBD Volunteers) have increased awareness. People are now more educated about the prevention of unwanted pregnancies. The CBDs go out to some schools, they basically talk about the 4 Too-s, you know, too old, too young, too many, too often. CBDs give talks in schools, they talk to young people, they talk to older people, to adults. The adolescents come, they ask us when they want privacy or when they want a method, before they would shy away. The program has also helped with STDs, the young people, they like the condoms very much and now every meeting (of the CBD Volunteers) we distribute a big box of condoms.”
(CBD Trainer)

The majority of participants pointed out that family planning services were having a direct impact on community reproductive health. Perhaps because of the devastating impact AIDS has had on the lives of Ugandans and the admirable educational and political commitment to reducing its spread, the affiliation between increased family planning education and sexually transmitted diseases (STDs) awareness was frequently articulated.

“People now are aware, they know the dangers, we have educated them and now they can educate their children. This CBD program helps not only to produce few children but also the dangers of getting AIDS. Now they are aware that if she suspects she has AIDS, she knows that she should not produce, because she gets weak and can die and so can her children.” (Local Council Leader)

Responses of local leaders and to a lesser extent, CBD Volunteers, indicated a general assumption that education about family planning by CBD Volunteers presupposes discussion and increased awareness about sexually transmitted diseases, particularly HIV/AIDS.

“Those who when they have those ‘sicknesses or diseases that cause shame’, now as a result of family planning services and particularly CBDs, they know they can now approach CBDs and get good information.” (CBD Volunteer, female)

At times, it was not clear if people's comments about increased STD education and awareness were articulating the present reality of the situation or their wishful preference for such services. All three male local leaders, for example, mentioned that, while younger men are more aware of sexually transmitted diseases, older males in their 50s and 60s still suffer silently with sex related problems “*down there*”. When probed, they thought these men should or could be receiving more information or referrals for treatment by CBD Volunteers but they could not clarify if this was actually happening.

Increased family planning acceptance is having a direct impact on women's lives

Respondents, both male and female, pointed out that women's lives are positively impacted by family planning use. The ability to space births and not produce so frequently was often mentioned as a direct physical health benefit.

“There has been some development particularly those who have been able to reduce births, those that have been able to slow their birth rate, extending the birth space. Some of them would get birth spacing so close but now woman have had the opportunity to relax a little, to take a breather and this is better for their bodies.” (former CBD Volunteer, female)

Respondents stated that women are sometimes unable or unwilling to access health care workers or trust them with their reproductive health concerns. They agreed that this problem had been alleviated by the availability of local, trained and trusted CBD Volunteers.

“Women with problems now have other people to trust. If you cannot help her, you can refer her. You can even go with her because sometimes she fears to go to the health unit alone. People now have people they can trust.” (CBD Volunteer, female)

Reference was also made to an increased sense of personal satisfaction or autonomy as a result of women having fewer children. Comments, from both males and females, were particularly focused on the potential for women’s increased participation in other activities as a result of family planning acceptance.

“Women now enjoy themselves more, now women can go for other things, she can socialize more without worrying that she left a kid at home, now she has time for other things, now she may even have time to be a CBD Volunteer.” (CBD Volunteer, female)

“First the people who have agreed to family planning are benefiting from it, people are feeding their children, clothing them and even educating them. It is the women who are suffering most from the lack of family planning. When they use contraceptives, they can be in charge of other things, they are not breastfeeding all year round, they are free to participate in other things.” (Local Council Leader)

Despite the positive changes, there is still more work to do

While positive about the changes in community health and development attributed to increased family planning awareness and acceptance, participants expressed a need for continued effort and education. All participants agreed that unplanned or unwanted pregnancies were still considered a serious health problem in the district, particularly for adolescents and women who already had many children.

“At this point it is still needed because parents are crying with many kids, some have eight or ten, and they don’t know what to do with them.” (former CBD Volunteer, male)

CBD Volunteers and trainers specified the need for continued and augmented community based services. The valuable contribution of village-based, house-to-house service was reiterated by local leaders. Some stated that although people’s awareness of the need for family planning had changed there had not been a subsequent change in their ability to access these services from health clinics.

The majority of respondents mentioned immobility, rain, long distances and prohibitive transport costs as reasons for women's inability to access clinics for family planning though male disapproval and poor quality services at the health unit were also mentioned by a few respondents.

"There is still a need also to provide services for those who are not mobile, those who have lots of kids and cannot seek services from health posts." (former CBD Volunteer, female)

"The CBD program is still needed here because family planning is the one way to come out of the poverty." (Local Council Leader)

7.1.2 Community Challenges to Family Planning

Opposition from males and religious leaders, as well as fear and ignorance were incessantly referred to as barriers to increased acceptance and utilization of family planning in the district.

"The argument between the spouses, the man wants to have children and the woman wants not to have, so the woman, she fears to have and sometimes she does not know better. Sometimes the man says how can you say that (about family planning) because my father had 20 children and he will tell her that even in the bible it is said that she must have many, the church leaders are a problem because they have a bigger congregation than we do." (former CBD Volunteer, male)

Male opposition and spousal disagreement about family planning

While a few participants indicated that male opposition was no longer as great a threat to family planning utilization as it once was in the district, most agreed that male opposition was a deterrent to contraceptive use. Participants appeared to assume that male's desire for more children is greater than that of women's. Male propensity for continuous childbearing was most often attributed to traditional or cultural beliefs that large families symbolized or ensured wealth and virility.

"Some men think that if they have many children, they will be seen as a big man. Some think that if you keep on producing, you become rich. They have girls, the girls get married and they get cows or money when they marry the girls off." (Local Council Leader)

Failure to include men or encourage their participation in the initial family planning activities in the district was mentioned as a reason for present day male opposition. Interviews with BHS staff confirm that a major oversight in initial family planning sensitization activities was a sole focus on women and complete inattention to men.

Communication problems between men and women, as well as an assumption that women were unable to negotiate family planning use with male partners, were frequently cited as reasons for male opposition to family planning. CBD Volunteers pointed out that sometimes, when women try to discuss family planning, there is an assumption on the part of male partners and other community members that she is “*playing sex outside the marriage*”. Also, because of the polygamous nature of some relationships, participants expressed the common assumption (whether real or perceived) that if a woman insists on limiting family size, the man will go elsewhere to reproduce. CBD Volunteers indicated that family planning decisions can have a devastating affect on marriages or unions, leaving the woman economically and socially vulnerable.

“Sometimes the men beat the women when they realize they are not producing. So they start putting a lot more restrictions, saying I should never see you at the CBDs, and if so I will punish you.” (CBD Volunteer, female)

Male disagreement about family planning, whether openly expressed or simply perceived or assumed, was cited as the main reason for women’s decision to use family planning in secret from their husbands.

“Some men are a big problem to family planning. Some women fear to even to be identified because they are afraid of their husbands. Because they were using without the consent of their husbands and so they would not come for services because they were afraid.” (former CBD Volunteer, female)

“Some women fear their husbands will find out and then so many problems will start. What is a woman if she is abandoned by her man?” (Local Council Leader)

The repercussions of male disagreement or lack of support were not confined to family planning clients but was also experienced by CBD Volunteers. Unexpected and unexplored outcomes related to the role of CBD Volunteer were illuminated in focus groups and interviews. CBD Trainers and Volunteers stated that, unintentionally, CBD Volunteers might be drawn into relationship dynamics of insecurity and jealousy.

“Marriages are sometimes getting problems as a result of CBD service, for example, a female CBD is supplying condoms to a man the wife might become jealous. Or husbands cause problems, if a male CBD is supplying to the wife the husband may be angry because he has the belief that to be recognized he must have many children” (CBD Trainer)

“Some husbands prevent CBDs from working. One of the problems is the men insulting us, abusing us verbally that we are the ones who are responsible; we are causing the women to not have the children. You try to explain to such a man and he will continue abusing you, especially the drunks. The men, they even threaten to take court action against us” (CBD Volunteer, female)

CBD Trainers and Volunteers also shared that some female CBD Volunteers experience disagreement and lack of support from their own husbands for their participation in the CBD program. Lack of financial remuneration for the efforts and activities of CBD Volunteers was articulated as a main reason for disagreement between CBD Volunteers and their spouses. Husband opposition stemmed primarily from the fact that CBD Volunteers spent time and energy on family planning activities that, in their minds, could be better spent on income generating activities that contribute to family survival and development. CBD Volunteers expressed frustration over their lack of self-sufficiency and their financial reliance on men and outside sources, despite the valuable contribution they were making to their communities.

“If we were being remunerated then we could ask the men to help us with family responsibilities because at least we are doing something, contributing something. But now, you cannot ask him for anything because if you do you will not be allowed to go again for those seminars (family planning training).” (CBD Volunteer, female)

Focus group discussions did not reveal that female CBD Volunteers experience difficulty using family planning because of their husband’s opposition. However, despite local leaders inference that women experience increased autonomy as a result of family planning, comments from CBD Volunteers strongly indicate that they themselves do not enjoy additional decision making power, equality or independence as a result of their increased knowledge, training and involvement in the CBD program. This is perhaps most blatantly illustrated by the following comments recorded during a focus group discussion with active, female CBD Volunteers:

“We just have to accept that men will always be above us and we have to accept this. You have to follow his rules and regulations, if you refuse and he orders you to go back home (to your parents) are you going to refuse?”

“Well, when you have refused to go by his orders, this is a mistake so it is you who has made the mistake, not him. If you do such a thing, you cannot see it as a fault on his part, it is the fault of the women.”

“When you are getting married you sign accepting to abide by the rules of the man. Even if the woman makes more than the man she has to kneel to him.”

Religious opposition

“Religion”, “the religious”, “church” and “the believers” were common refrains when participants were asked what prevents people from accepting family planning. According to participants, religious opposition ranged from encouragement of the fatalistic belief that the number of children one has is “up to God” and therefore out of one’s control to the bolder declaration by religious leaders that using family planning methods is synonymous with “killing babies”.

Although it was sometimes difficult to clarify if religious opposition to family planning was as real as it was perceived or assumed, participants from one study site provided concrete examples of religious leaders impeding family planning activities, most notably in the discriminatory treatment of CBD Volunteers. One CBD Volunteer was actually forced to abandon her CBD duties as a distributor of contraceptives because of pressure from her Catholic Church priest, however, she continues to educate about family planning and refer clients to other CBD Volunteers or health units.

“Religious interference, religion interferes with our program, they don’t want us to supply, and they say it is bad, that we are killing, that we are murdering babies by using family planning. They go ahead and mistreat our CBDs: they refuse holy communion, baptism, funeral rites” (CBD Trainer)

“Catholics not in favour of family planning, they have their own program, they want as many people as possible to be born. We had one CBD trained but she was involved in the Church business, she was summoned to explain what she was doing and she ended up quitting from distributing, she returned her supplies but she continues to tell her clients to go to other CBDs because she knows the importance of family planning.” (Local Council Leader)

Only one participant, a local leader, appeared confident that religious opposition was no longer a barrier in the district. When initially asked about the interaction between family planning activities and religion, he responded:

“Religion? No problems. The Catholics and Church of Uganda, they encourage it, they say there should be family planning, no big problem there. We do sensitization even in Church, even at funerals, anywhere there is a gathering” (Local Council Leader)

However, for unclear reasons, he appeared less optimistic by the end of the interview when he spontaneously stated:

“Religious, Catholic, Bisaka, they say that a man should have as many as possible so they are discouraging family planning. They say it is God’s will to have many children” (Local Council Leader)*

This confusion about religious opposition may be attributed to the confusion within the religious organizations themselves. At a meeting of religious leaders organized and facilitated by BHS reproductive health staff in Kabarole in 1999, religious leaders from a variety of faiths including Catholics, Anglicans and Muslims, agreed that there are generally large discrepancies between

* The Bisaka religious congregation was founded by an ex-communicated Catholic priest, named Bisaka, in the early 1990s. Bisaka is growing in numbers and popularity, particularly in poor districts of Uganda, despite the obligatory financial or in-kind contributions required from members to support the all-male Bisaka spiritual leaders.

official doctrine or church policies and what religious leaders at the grassroots levels condemn or condone. Similar sentiments were aired during a meeting between the Bisaka (see endnote on page 76) religious leader and BHS reproductive health staff, including the researcher, held in Katooke, Kabarole in October 2000. The meeting was called by BHS staff to ascertain the Bisaka reaction to family planning and to discuss accusations that some CBD Volunteers were being mistreated by Bisaka religious leaders in some areas of Kabarole district. The Bisaka admitted that although his “Bible” encourages followers to only have the number of children they can care for, his male “Bishops” in the villages, particularly the older ones, often do not know what family planning is and therefore condemn it out of ignorance.

Fear, ignorance and misconceptions in the community

The majority of participants articulated that women’s fear over potential side effects of modern family planning methods and a seemingly endless array of community rumours and misconceptions about the possible physical repercussions of using these methods were major deterrents to increased contraceptive use. The most commonly cited fears were that users would become permanently infertile or sick and weak affecting their ability to work and that future babies would be “deformed”.

“Women would fear that they would fall sick. Disability is also a worry for them - that women would produce kids with deformities, disabilities like crippled or something.”
(former CBD Volunteer, male)

“First of all what I think it (fear of side effects) is psychological because traditionally people were not used to using family planning methods especially these modern ones such as pills and injections. Some of them are welcoming the program but others fear these side effects. These rumours, some say you will become infertile for some time.”
(Local Council Leader)

“Ignorant people are also a problem for us. These are people who think when you use pills they become barren for life or that it increases blood pressure.” (Local Council Leader)

Participants agreed that the biggest fear or assumption specific to the use of oral contraceptives was that women who take pills become overweight.

“The other problem that they do not like is that when you use pills women gain weight, they get big. When you become too fat you even fail to do any work for yourself. When you become so fat you cannot do anything even walking a little and you are sweating and you become sick.” (active CBD Volunteer, female)

“People fear family planning. They say women who use pills become too fat, that they become weak, periods change.” (Local Council Leader)

An unexpected concept mentioned by both CBD Volunteers and local leaders was the suspicion that family planning methods were part of an international conspiracy to eradicate Africans. Although participants were unable to speculate on the source of this rumour, they agreed that it was strongly upheld by some villagers, particularly respected community elders.

“There are those who believe that the bazungus are deceiving people. They believe that the bazungus (white people) bring those pills and methods here but the people fear that they are not meant to do anything with family planning but instead they inflict diseases on the people. That the bazungu want to kill Africans.” (former CBD Volunteer, male)

Interestingly, adolescents and teachers also reiterated this misgiving during high school presentations about reproductive health. On one occasion, the Head Master of one rural school asked the Researcher to comment on his suspicion that family planning “*was another ploy by white people to stop Africans from having babies*”.

A similar idea was also expressed during the meeting of the researcher and BHS staff with the Bisaka religious leader. After requesting an explanation of family planning and responding very favourably to the concept, the Bisaka summoned for one of his “Bishops” to retrieve “the belt”. A seemingly regular leather belt was produced but, pointing to a silver magnet behind the belt buckle, the Bisaka explained that this magnet caused male sperm “to dry up” and subsequent impotence in men. He further explained that this belt was manufactured by “bazungu” and was being sold in cities in Africa in an attempt to eradicate the African population. Surprisingly, the issue of “the belt” was again raised at a later date by a school teacher during a school presentation facilitated by the researcher and the BHS Adolescent Sexual and Reproductive Health Consultant.

CBD Trainers and local leaders tended to attribute fears about side effects to low education levels, specifically a lack of understanding of physiology and how contraceptives actually work in the body, and desperate attempts by uneducated individuals to explain and rationalize illnesses in the absence of appropriate medical advice and knowledge. CBD Volunteers, however, were more likely to blame women’s fears about side effects on rumour mongering and malicious gossiping which serve to further confuse clients despite the education provided by family planning providers.

* bazungu is the plural form of muzungu which means white person.

“Rumours, misconceptions... you (as a CBD Volunteer) are trying to say this, to tell the truth about family planning but then there are other people who are saying ‘look what happened to this person, that is why she has a crippled baby.’ Other people say ‘see this person has been using pills for two months and the problems she has been having you cannot imagine’. So many rumours going around town.” (former CBD Volunteer, female)

“About the misconceptions of side effects, I have many examples. I was providing a woman with pills and she had some problems, she goes and talks to other people and they say ‘didn’t I tell you, you would have problems’ and then when I went back to her to encourage her she would not want to talk to me. Another example, if a woman has a problem where she has long periods (because of a family planning method) the people say ‘see we told you about those pills’ and she is discouraged so she stops.” (former CBD Volunteer, male)

7.1.3 Community Perspectives on CBD Program Related Problems

When asked about the program related problems or challenges faced by CBD Volunteers, the overwhelming response from all participants was that they “are not properly facilitated” or they “lack facilitation”. In Ugandan English, the word “facilitation” was discovered to be an all-encompassing one. When used in reference to the CBD program, facilitation was literally any means needed to ensure that CBD activities are carried out as well as anything that would make the work of the CBD Volunteers and Trainers easier. It can therefore include a wide range of program implementation and management variables such as remuneration, motivating factors, incentives, worker morale, Volunteer recognition, support, supervision, training and information, uniforms and raingear, information, education and communication (IEC) materials.

Not even a bar of soap

All participants, without exception, cited lack of remuneration or rewards for CBD Volunteers as the major program related problem. It must be noted, however, that very few participants referred to the need for CBD Volunteers to receive actual salaries. More often, “remuneration” implied modest cash allowances for lunch or travel and non-monetary rewards or token incentives such as soap, lunch or other food items.

“You go to mobilize people, you spend the whole day and you have not eaten, you have gone hungry and you have not been given an allowance.” (former CBD Volunteer, male)

“It is not that we wanted to be paid primarily but we needed some help because we are poor people, we expected some little help and we deserved some help because of the good work we were doing.” (former CBD Volunteer, female)

“The main problem is that they are not properly facilitated, we have seen that it is necessary to have even a piece of soap for their motivation.” (Local Council Leader)

In the majority of cases, the underlying basis for complaints of lack of “remuneration” appeared to be a genuine concern for the livelihoods of CBD Volunteers and a keen recognition of the fact that they are poor. Like the clients they serve, most CBD Volunteers live in poverty, are overburdened with multiple commitments and the daily struggle for survival and are often unable to meet the basic needs of their families.

“To work for nothing is too much especially if you have hungry children at home.” (CBD Trainer)

“You cannot continue working for nothing when you do not have what you need to live, you need to be facilitated.” (former CBD Volunteer, female)

“Working for free especially these days people do not have the guts to go on because they have other things to do, we need to give them some small things, some small allowance and transport some little money especially to come these monthly meetings.” (Local Council Leader)

“The biggest problem is how to reward them. They know it is voluntary work but volunteerism has its limits. You cannot be a volunteer for years and not expect anything.” (Local Council Leader)

Long traveling and walking distances and lack of transport (bicycles or travel allowances) were frequently mentioned as problems faced by CBD Volunteers, particularly with regards to traveling to the health units for monthly reporting meetings. Perhaps because it was rainy season when this data was being collected, distressing weather conditions and lack of protective wear such as umbrellas, raincoats and gumboots were also problematic for the majority of CBD Volunteers. Lack of uniforms (or some way of identifying the CBD Volunteer) was also frequently mentioned by participants.

“Some CBDs are very far away, they come here for meetings, they need food, drink, the sub county is very big, it is very strenuous. They lack transport. Moving in parishes is not such a problem. The problem is moving from their place to the Health Unit, that is very far.” (CBD Trainer)

“You walk a lot you walk through the village and you do not even have money to buy soaps.” (CBD Volunteer, female)

“You walk, it rains, you get wet.” (CBD Volunteer, female)

“You are walking and you don’t even have a piece of bread to eat.” (CBD Volunteer, female)

“Spouses say to us ‘you have been away all day (at the CBD monthly meeting) and you come home without even a bit of salt.’” (CBD Volunteer, female)

There was general agreement amongst a few participants, particularly CBD Trainers, that lack of remuneration or compensation was negatively affecting the impact and intensity of CBD and family planning activities in the district.

“Because it is voluntary work, therefore when they get a job they must leave CBD work. If they are getting some sort of allowance I don’t think they would drop out but they need some facilitation. Most CBDs are not very active, they don’t mind, they have few clients because they say after all, they are volunteers, but if they received some facilitation they would get more clients.” (Local Council Leader)

This lack of remuneration or compensation was also thought to contribute to the community ridicule experienced by some CBD Volunteers. In villages characterized by poverty and desperation, there is often an understandable suspicion that if one is doing community work, she or he is either being “idle” and unproductive or accruing benefits, financial or otherwise. Some CBD Volunteers sensed a lack of support from community members, and at times experienced blatant ridicule from other poor women, for their involvement in CBD Volunteer work.

“Other women ridiculing the CBDs, women who are busy in the fields and when she is passing by she is just laughing at you, saying ‘what are you getting from that work’, she thinks you have time to waste.” (CBD Volunteer, female)

“The other accusation is that they (the CBD Volunteers) are women who are idle, who come to create problems and to kill their children.” (CBD Volunteer, female)

“The other thing is that when people see you coming with the chairman, to get people to listen, they think that you are eating money with the chairman and yet you are not getting anything.” (CBD Volunteer, female)

It’s like chasing the sun

Interviews and focus group discussions revealed that low morale amongst CBD Volunteers constituted a major program-related challenge. CBD Volunteers often expressed that despite their substantial efforts and time commitment, they were *disappointed* or felt they were *wasting their time*. This frustration, often accompanied by a sense of failure, is suggested in the following comments:

“Distance for example the CBDs who are supposed to be going to seminars, they walk a long distance, she stays all day, it is a waste of time, she gets no food, no money, she has no transport.” (CBD Volunteer, female)

“We persevered but we failed.” (former CBD Volunteer, male)

“You come to the training seminar for three weeks and in that time you cannot work. And you have no time to do anything else. And this discourages you. And you say to yourself ‘You have wasted your time.’” (CBD Volunteer, female)

“It’s like chasing the sun, we are not getting anything, we are engaged in a venture where we are not going to get anything from it.” (CBD Volunteer, female)

When discussing their attempts to meet the needs of their clients, CBD Volunteers (both active and drop outs) expressed particular frustration and disappointment. Generally such comments were preceded by expressions of frustration that CBD Volunteers were limited in the number and types of contraceptives they could offer clients.

“You just fail as an individual ...some of them (clients) wanted methods that we were not able to provide...So CBDs would spend the whole month without any clients because people wanted what you did not have.” (former CBD Volunteer, male)

“A related issue is that you know some of them have been told bad things about pills and so they are not willing to use the pills so the only thing they would be willing to consider would be permanent methods which can not be supplied by CBDs so this is frustrating for clients and CBDs.” (former CBD Volunteer, male)

“Some people might prefer injections and we cannot provide that so you ask yourself why should I go when I cannot give them what they want, when I cannot satisfy their needs.” (CBD Volunteer, female)

According to participants, broken promises and a feeling that problems and issues were not being adequately recognized or addressed further disappointed CBD Volunteers and Trainers and contributed to their lack of morale. The frustration of broken promises was expressed by CBD Trainers and Volunteers and was particularly prominent when discussing reasons for CBD Volunteer discontinuation.

“So they told us that when we get problems we should make a list of these and bring them back and so we did this and then they could not solve them and they could not facilitate us and this discouraged us.” (former CBD Volunteer, male)

“We were always being promised things like soap and then never getting anything and this kind of discouraged us.” (former CBD Volunteer, male)

“We were encouraged to start projects like an agricultural project and we started this, started growing, cultivating, and then we asked for help but got nothing. It was in vain.” (former CBD Volunteer, female)

CBD Volunteers and Trainers complained of being asked to express their ideas and suggestions and then never receiving any response or reaction. Although many participants acknowledged that lack of funds was a probable reason for the lack of response, a substantial number of CBD Volunteers appeared to assume that this lack of interest stemmed from the fact that the CBD program relies on volunteers, not paid staff, and is therefore somehow less worthy of support and attention. Lack of feedback was taken as an indication that CBD problems and issues were not

being listened to or taken seriously by program organizers. Some pointed out that since they were “not looking for hand-outs”, but instead were expressing their commitment to working even harder, for example, in income generating projects, they expected feedback and were even more disappointed when it was not forthcoming.

“The CBDs from the different parishes, each came up with proposals, ideas on projects to make money, to make ends meet, we passed this information over to GTZ but no response yet.” (Local Council Leader)

“The CBDs have started a small loan fund. Income generating is most important for the CBDs. They tell us we should start income generating. We have asked donors for money but no support yet, they never get back to us. Also, we do not have enough IEC and we were promised money for drama in January and February, it is really the best way to educate people and we have not heard anything back since.” (CBD Trainer)

“People like you guys came here in the past and asked us about our problems and they did not bring back a report and they have never given us a feedback, we don’t know whether our issues were accepted or if they just threw them away.” (former CBD Volunteer, male)

You cannot train someone and then just dump her there

Lack of support and recognition from various levels including program organizers i.e. GTZ Basic Health Services and district health offices, Local Councils and health units and in various forms including training, supervision, incentive schemes and supply of basic program materials such as information, education and communication (IEC) materials and pens was frequently cited as a problem experienced by CBD Volunteers.

Other than the extensive time commitment required (two to three weeks), there were no specific complaints about the initial training seminar received by all new CBD Volunteers. Problems were more related to a lack of follow-up after training and a lack of refresher courses to reinforce or supplement training curriculum content. The majority of participants also mentioned a severe shortage of appropriate and effective IEC materials as a problem, particularly as it related to client’s low education levels and the abundance of misinformation present in the villages.

“You cannot train someone and then dump them there. You cannot forget about them and expect them to do a good job on their own.” (Local Council Leader)

“The training they get, it is not enough. This world of ours keeps changing so they need training all the time, they need some refresher courses, or else those who received training many years ago do not match up with the modern world.” (Local Council Leader)

“IEC materials? What IEC materials? There are no flipcharts. I have one set, my own flipcharts but the CBDs do not have anything to show their clients.” (CBD Trainer)

Lack of training and experience was also provided as a reason why CBD Volunteers are not accessing many adolescent clients. CBD Volunteers pointed out that CBD Volunteers lacked specific training on how to communicate with youth and how to deal with their needs. A few respondents, however, particularly Local Council representatives, noted that CBD Volunteers were not capable of accessing youth due to differences in demographics and perspectives.

“CBDs do not have enough training/experience on how to deal with young people.”
(Local Council Leader)

“The CBDs have two, three, four children so they are not good for young people who do not yet have any children. Some CBDs are too old; they are no longer producing so they cannot communicate with some certain ages. They may give biased opinions, someone with ten children telling other people not to produce, it does not work.” (Local Council Leader)

The majority of CBD drop-outs and a few active CBD Volunteers expressed concerns about a lack of support from health unit staff, particularly if or when the CBD Trainer was temporarily unavailable or transferred. This echoed the sentiments expressed during the pilot focus group with active CBD Volunteers in Katooke who articulated fear of what would happen to them and their program when their trainer was transferred.*

Overall, among all participants, there appeared to be a tendency to assume that GTZ “owned” the program and was therefore primarily responsible for its implementation and financial management. Local Council (LC) representatives often mentioned that program organizers, specifically GTZ Basic Health Services or “the District” should be taking a more active role in supplying support to the CBD program. CBD Trainers were more likely to express their frustration over a lack of financial support from Local Councils at the sub-county level than to criticize program organizers. They did, however, admit that Local Council representatives had been actively involved in the initial selection and recruiting of CBD Volunteers. This was confirmed in interviews with Local Council representatives who also expressed frustration that they were unable to provide more substantial financial support to CBD Volunteers.

“You ask about Local Council level three support. They promised us 500,000 shillings for the whole year but we have never received any. We get nothing from them.” (CBD Trainer)

* Transferal, particularly of committed and motivated health unit staff, is often considered inevitable in Uganda where poor health unit service delivery is further aggravated by high staff turnover, low staff morale and poor remuneration.

“They are not concerned about health here. The LC leaders are not concerned about health, they don’t pay to the health unit. We only have cost sharing to support us, and since right now there is a drought the people do not have money to pay so we have to treat them for free.” (CBD Trainer)

We were involved from the beginning, the trainer invited us, we helped the trainer to recruit. We knew we needed someone who was capable of doing the work, someone who has courage to serve his fellow people. We selected those who can educate the others, those who have courage to serve others because it is a free (voluntary) service. (Local Council Leader)

“Where there is a possibility we support the program, A little but some, if we had more money, we would give more money but we are limited by income.” (Local Council Leader)

“We gave a little money for a party last year, this was very little, once in a while we give, It is a problem with money, people are sensitized now, it is mainly a question of money.” (Local Council Leader)

We are frustrated but committed

It must be noted that lack of commitment or enjoyment for the job cannot be added to the list of frustrations and program related challenges facing CBD Volunteers described above. Many CBD Volunteers, both active and drop-outs, spontaneously offered expressions of CBD Volunteer commitment and recognition that their efforts have made a difference:

“We know women’s problems - you produce lots of children and then you die and you produce lots of children and you cannot even have money to let them go to school. We really love to help women, we have that commitment, and the problem is that we are becoming frustrated.” (CBD Volunteer, female)

“That work was good. Although we had all these problems, we liked it.” (former CBD Volunteer, male)

“What really makes me happy that I was a part of this is that I can see the benefits. Some people express their gratitude now for the work we did back then, they are better off because of fewer children. Our work was appreciated by the community.” (former CBD Volunteer, male)

7.1.4 Perspectives on How to Increase Family Planning and CBD Acceptance

“Increase community education, awareness and sensitization activities!” This was the resounding response by all participants when asked what could be done to enhance community acceptance of family planning and CBD Volunteers. Participants stated that family planning mobilization activities cannot be limited to one or two events per year but instead must take place on a constant basis so that people have opportunities to hear the messages in a variety of forums and formats. Many said that family planning people, as well as Local Council representatives at all levels, must take advantage of all opportunities and gatherings of people, even funerals and church services, to *“educate people about the risks of too many children and the benefits of lowering the birth rate.”* The persistence and patience required for family planning education and awareness, as well as for family planning providers, is indicated in this comment from an active CBD Volunteer:

Facilitator: *“What do you think should be done to ensure people continue using the services?”*

Participant: *“Keep with them, keep mobilizing them, and don’t give up on them. And keep with us, don’t leave us, don’t give up on us.”*

Participants also pointed out that family planning messages must be offered clearly and consistently in ways that local people could easily understand. There was widespread support for utilizing the news media particularly the local radio station, Voice of Tooro, and popular education techniques such as drama, drumming and singing to get messages to the people.

“I feel if we could encourage the drama and drummers they can give better information, a mixed group, they receive the message and then they disseminate, we have used them to give out messages about health, sanitation, poverty, family planning. They are not so expensive and it is free for the people. The drumming can be a supplement to the CBDs – the CBDs give important information and then afterwards the drums come in and repeat the main messages. They need intensive information because many of them are illiterate.” (Local Council Leader)

Many participants proposed that CBD Volunteers were in a favourable position to contribute most to community education efforts, particularly if their numbers and training were to increase.

“The reaction from the public about family planning is not 100% but at least 80% of it is positive. We must increase this percentage of the positive side by increasing the number of CBDs.” (Local Council Leader)

Meeting religious leaders and opening dialogue with them to ensure they understand family planning and its benefits was also offered as a suggestion for increasing community acceptance of family planning. In particular, CBD Volunteers stated that discussions should be held with

religious leaders in order for them to better understand the positive role of CBD Volunteers. Local Council leaders suggested that CBD Volunteers receive special training on how to approach religious leaders for support and how to counteract the negative comments made by them.

“If we can address some of the religious leaders, they need to be addressed because they seriously mistreat our CBDs, maybe we can follow the hierarchy and reach the religious leaders from the top to the grassroots.” (CBD Trainer)

Increasing the active involvement and participation of men, including male CBD Volunteers, was frequently mentioned by participants as being crucial to the increased utilization of family planning in the district. However, a few male participants also pointed out the importance of focusing on women’s participation, education and empowerment.

“Of course traditionally men are the problem, but we must keep on, educating our people, especially with the young people. Men may not actually like it but women must stand on their two feet and say ‘no, we must space the rate of human birth, we need to plan because at the end of the day we are the ones suffering’. You can imagine, you are pregnant, one on your hip and another one there at your side because at the end, it is the women who suffer much so they must be encouraged to start especially now with this gender balance. The women need to know to plan the family; I think together it can be done. I am not suggesting that women should be doing it themselves, as they must involve the husbands, so that they know about the programs. The CBDs should be used to sensitize the men, it would be a good idea to get more men as CBDs.” (Local Council Leader)

“We should focus on the family planning methods that can be used by females. Females should be equipped, for example with female condoms, not the men. Many husbands do not want to use. Men are not as careful as women. Men don’t seem to care when women are pregnant, he says it is her problem, not his. It is the women who suffer the most. But to avoid accidents we need to rely on the women.” (Local Council Leader)

Participants also suggested that adolescents should have better access to family planning education and services. When probed, strategies offered for increasing the participation of adolescents in the CBD program included training CBD Volunteers on how to approach youth, training youth to deliver services to their “age mates” (a Ugandan English term for peers) and relying on teachers to educate school-based adolescents.

“We need to be getting young people and they can also listen so that when they grow up and get married they can plan their family we should be reaching the males and at the same time we must reach the young people because at the end of the day they are the parents of tomorrow. The age of the CBDs may be a problem; there is a problem of older people not addressing the concerns of young people. If possible, we could train age mates. We can also involve these teachers so that they can educate these young people so that when they grow up they will know. With time, with time.” (Local Council Leader)

“For me, with these CBDs, the youth should be included. Include youth, train them, and include boys and girls.” (Local Council Leader)

7.1.5 Suggested Solutions For Meeting CBD Program Related Challenges

Incentive schemes

When asked for suggestions on how to combat low morale of CBD Volunteers and ensure their continued participation in the program, participants mentioned that remuneration, compensation, monthly motivation and incentives should be provided to CBD Volunteers.

“The other thing is remuneration, even the lowest people on the bottom should be paid, even you and the researcher have come here with transport, you have been facilitated and CBDs also need this.” (former CBD Volunteer, male)

“I would suggest some sort of motivation especially for the monthly meetings, a lunch allowance for the meetings, maybe 1000 per CBD per month so at least they can feel to work more.” (CBD Trainer)

Again, it was made clear that only meager, humble requests for financial support were being made.

Facilitator: “How much do you think you would like to be paid every month if it was possible?”

Participant 1: “You should just be able to earn enough to get some salt, some soap, we really are not asking for so much money but just the ability to get some things we need.” (former CBD Volunteer, female)

Participant 2: “Personally I would like to have made enough money to get my lunch.” (former CBD Volunteer, female)

Participant 3: “Remuneration, like being given lunch when you are on the job, when you are doing your work.” (former CBD Volunteer, male)

The provision of lunch and travel allowances as well as protective wear such as umbrellas were most frequently mentioned as specific ways of compensating CBD Volunteers for their work. Some participants also mentioned the need to develop a system of competitions and contests so that CBD Volunteers who work the hardest, e.g. obtaining the most new clients in a year, would be recognized and rewarded for their efforts.

Providing CBD Volunteers with bicycles was offered as a suggestion for dealing with the long walking and traveling distances endured by CBD Volunteers. Bicycles were also viewed as ways to increase the communication with CBD Volunteers as well as a suggestion for decreasing the ridicule they sometimes experience from community members.

“If, for example, we are provided with a bicycle because then the other women -- those who are busy with family income -- they will not ridicule us because they see we are getting something.” (CBD Volunteer, female)

Similarly, the provision of uniforms would serve the dual role of allowing CBD Volunteers to be easily identified as well as to be respected and recognized as legitimate health workers.

“At least they need uniforms so they we can be identified as CBDs, so people can see you and they know to come to you if they want to know something. With a uniform, no matter where they are going they will be recognized and respected. The local people will be thinking well she is learned and therefore she will be respected.” (CBD Volunteer, female)

Even the suggestion of offering study tours and exchange visits to CBD Volunteers, while initially proposed as a way to increase the training and knowledge of CBD Volunteers, was noted as a way to increase Volunteer motivation.

“Exchange trips, study trips - in the absence of funds this will help them to like their work more, to see how important is their work, to see how others are doing things.” (Local Council Leader)

Providing encouragement and financial support to CBD programs interested in improving their drama and drumming initiatives and income generating activities was yet another solution offered by many participants, particularly CBD Volunteers and Trainers. Support for income generating activities was not limited to financial input or set-up funds but included issues of capacity building and training. This type of support was viewed as a key way to increase Volunteer morale and ensure the sustainability of the program.

“We have a brick laying project, it is an income generating project for the CBDs, we have savings and credit, we have a project for drumming and dancing. We need help with all of these activities to make them stronger. All of this was brought to them in order to motivate them to stay, to come back especially for the monthly reporting meetings. Really, this is the best way to keep the CBD program going strong.” (CBD Trainer)

“If we could get them some income generating projects, something so that they can earn some funds. This would reduce their reliance on outside help, they are lacking means for this.” (Local Council Leader)

One Local Council representative indicated the importance of having the decision about types of income generating projects left in the hands of the local people and not dictated by outsiders.

“The CBD Volunteers need income generating projects, but this is one way also to support themselves. I don’t know what types of projects would be good in this area. You see we have the experience of seeing these projects fail because they have to get used to the idea that the project is ours, not mine, so we can sustain the project. Maybe a piggery, but the idea for the projects has to come from the CBD Volunteers themselves or else it would not be sustainable.” (Local Council Leader)

Enhance support from above

The cry for increased support for CBD Volunteers and the CBD program was loud and constant. Most participants saw this is a solution to the many logistical and morale challenges faced by CBD Volunteers.

Regarding program logistics and implementation, “increased support from above” encompassed a variety of ideas for improving the knowledge and activity of CBD Volunteers including increasing the number of CBD Volunteers available, supplementing and intensifying present training activities and refresher courses for CBD Volunteers as well as health unit staff and providing more and better IEC materials. Local Council leaders frequently mentioned that CBD Volunteers should receive training in other community health issues, in addition to family planning, and some CBD Volunteers stated their desire to receive training in how to give injections to their clients.

“Now they are few and the demand is very high, we need more because they are helping my people there.” (CBD Trainer)

“I would suggest that CBDs be given more training and ideas on how to reach more clients, how to deal with the program and the problems they face” (Local Council Leader)

“CBD Volunteers need to be given more training they could offer better service Right now some of our sick people in the villages can fail to get to the health unit because of transport so if CBD had access to these little drugs they could offer better service.” (Local Council Leader)

“Increase support from above” also served as a request for increased recognition, respect and legitimacy for CBD Volunteer work. Participants acknowledged that the mere presence of program organizers, particularly doctors, in the villages could facilitate CBD efforts and increase the legitimacy of family planning.

“Even those people who are in authority they should put more effort into the exercise of family planning they should visit the villages, so they confirm to the people in the villages that what the CBDs are teaching the people is true” (CBD Volunteer, female)

“Occasionally you also need to bring people from the headquarters to the people to meet with the clients to see them” (former CBD Volunteer, female)

Finally, CBD Volunteers expressed a desire to have their perspectives considered, their issues listened to and their ideas and suggestions entertained. They stated that honest communication, immediate feedback and better coordination between them and program managers would greatly ease their concerns and improve their sense of purpose.

“There should be good coordination between those above us and us so if we tell these people above us about the problems in the villages then it should be availed” (former CBD Volunteer, male)

“If you put those problems we have told you about under consideration then we know that the program will take off” (CBD Volunteer, female)

“There should always be feedback whenever such problems are presented to people like you, like today during this research” (former CBD Volunteer, male)

7.2 Adolescents’ Perceptions on Family Planning and the CBD Program

The content analysis of data from the four focus group discussions held with school-based adolescents (14 – 20 years old) in Kabarole revealed three major themes: 1) an abundance of misinformation, 2) obstacles to accessing family planning information and services and 3) elements of youth friendly services are quickly identified by adolescents. These themes and subsequent sub-themes are described below.

7.2.1 An Abundance of Misinformation

There was general agreement amongst adolescents that unplanned pregnancies and sexually transmitted infections were serious problems for young people in their areas and their comments demonstrated a clear awareness of the relationship between youth sexual behaviours that were “not clever” and the unintended consequences of pregnancy or sexually transmitted infections. Most adolescents seemed to understand the concept of family planning and were able to provide official or academic definitions such as “it is a measure of controlling population increase”. However, many appeared to be under the assumption that family planning, in its official capacity, was something confined to married couples, or “*mothers and fathers*”.

Despite the ability to list various contraceptives available for preventing pregnancy, adolescents lacked specific details about these methods and how they actually work in the body to prevent pregnancy. A post focus group conversation about hormones as they relate to the use of oral contraceptives indicated not only that a word did not exist in Rutooro to adequately describe

hormones but also that female participants were completely ignorant of the concept. This ignorance may be attributable to an overall lack of information concerning bodily functions and sexual maturation as indicated by their seemingly naive questions regarding menstruation, masturbation or virginity.

A similar lack of awareness and fundamental ignorance of sexual organs and related bodily functions was expressed by a local Teacher Training College during an educational session facilitated by the researcher and BHS staff. First and second year students (soon to be teachers), ranging in age from 18 to 25, were asked to write their pertinent questions on pieces of paper after viewing a video about one Ugandan teenager's experiences with unwanted pregnancy and the subsequent botched abortion. Over 125 questions were collected and answered during the next scheduled school visit by reproductive health staff. A few of these questions (exactly as asked) are included here to indicate the lack of information and misinformation rampant amongst adolescents:

"Some people say that if a lady stays without having sex for a long period of time, that the juices can lead her to a certain illness hence ending up to be operated so as to remove them. Is it true?" (19 year old adolescent female)

"Whenever I have sex I finish within two minutes and I feel I should continue (in need) of having sex. What causes this?" (20 year old adolescent male)

"Can masturbation reduce man's power if done everyday?" (23 year old male)

"I was told that a woman has safe days during which she cannot conceive. When do they happen and how long do they take? Reply me." (22 year old female).

The majority of adolescents shared an alarming number of misconceptions about family planning methods and expressed considerable anxieties about the consequences of modern methods of contraception, particularly oral contraceptives. Many participants expressed a belief that family planning methods weaken a woman's health.

"So the pills, one takes them and is constantly sick. There is a woman in the village who takes pills and she cannot spend a week working, it disturbs her health." (male student)

Even condoms could be hazardous according to this 18 year old male:

Participant: *"You can get it deep inside the woman and the girl can die if you do not take her for immediate assistance."*

Facilitator: *"Is this true?"*

Participant: *"I saw this in a newspaper. She had played sex with a boy and the condom slipped there, it went up and she tried to remove it but she failed and she did not tell anyone and she died."*

According to adolescent participants, contraceptives were particularly bad for young people. A variety of rumours, misconceptions and misunderstandings about methods and their supposed side effects was offered, most commonly that they can cause infertility, deformities and disabilities in future children.

"Because we hear that when people take Pill Plan, they will have babies with one hand or no arm and we want to know how people can avoid these deformities." (female student)

"But we hear that if you start taking pills when young, you cannot have children, you will not be able to ever have a baby or you will have crippled children and when you take the pill you start bleeding too much." (female student)

Many participants reported that parents and older siblings were the main sources of this misinformation. When asked if they talked to their parents about issues of sexuality or family planning, however, the resounding chorus from both male and female adolescents was "no". When this discrepancy was pointed out, adolescents in one focus group explained that, although one-on-one conversations about sex between, for example, mother and daughter, were rare, adolescents became aware of the views of parents during their lectures and scoldings or via parents' conversations with third parties.

Participant: *"I was told that using pills can make me bleed too much when in my monthly periods and that I can be an abnormal size."*

Facilitator: *"Who told you that?"*

Participant: *"my parents" (female student)*

7.2.2 Obstacles To Accessing Family Planning Information and Services

A lack of trusted information sources

Adolescent's unrestrained enthusiasm to participate in focus group discussions and their incessant questioning once in groups were perhaps the strongest indications of their keen interest in (and in some cases, desperation for) opportunities to access information on sexual and reproductive health issues. Girls, in particular, for example, were willing to lie about being randomly selected for the group, loitered cautiously around the focus group discussion site trying to overhear the content or waited patiently for focus group discussion to end in order to approach us with a carefully formulated question.

Adolescents complained of a shortage of readily available and reliable educational materials. Although many participants expressed appreciation for the information sessions provided by the GTZ Reproductive and Sexual Health Educator, there was general agreement that the reproductive health education received in schools was inadequate to meet their needs. They specifically requested more IEC materials, such as videos, Straight Talk newspapers, books, posters, pictures and information programs on local radio stations.

Participants stated that there was a lack of informed people they can turn to in order to ask questions or receive correct information. Fear of “losing school” or being forced to leave your studies was the most common reason cited for not requesting information from teachers, nurses or Head Masters at school. Though some participants complained there were no trusted adults to turn to at school, (females, in particular, discussed the dearth of female teachers and counselors), a sense of entitlement to school sexuality education was not easily detected in students. Some participants seemed to assume that this education was synonymous with encouraging bad behaviour. Males, in fact, openly commiserated with Head Masters’ decisions to immediately dismiss pregnant students (the females not the fathers) or refuse the availability or distribution of condoms at the school site.

Facilitator: *“What happened to the (pregnant) girls?”*

Participant 1: *“They left school. They don’t fit in the school anymore. The rule of the school says you must go. They set a bad example, others will think it is alright for them to become pregnant, you are seen to be harmful to the school.”*

Facilitator: *“Where do students get condoms? Are they available in the Head Master’s office?”*

Participant 2: *“No, they cannot make this mistake.”*

Facilitator: *“Why is this a mistake?”*

Participant 2: *“It would be a mistake because it is as if they are encouraging students to have sex. The school regulations stop the business of sex...they say you cannot play sex at school so it is impossible for them to bring condoms here so as I have told you the business is done in secret.”*

When asked if they could approach their parents, adolescents expressed fear of a negative parental response, most notably the fear of being taken out of school or of being perceived as promiscuous. Some participants also commented that since most parents in villages receive even less schooling than adolescents, they have even less correct information about family planning

than students. The following discussion demonstrates student's apprehension to discuss family planning with their parents:

Facilitator: *"What about your parents, are they a good source of information?"*

Participant 1: *"They don't encourage young girls because they think when you take pills you will get weak. They say 'if I see you with these pills you must leave this house', so you fear to use them."* (female student)

Participant 2: *"Or they believe that if you use them you are promiscuous, you are a Malaya (a prostitute), this is parents but also other people in the community. They will say that she is sleeping with every man. They can even stop you from schooling. Even marriage becomes difficult, they will think you will never be able to marry, you will not make a good wife because you will always be looking to other men."* (female student)

Deterrents to accessing services at the health unit

Overall, a negative attitude towards the use of condoms was not detected. Participants agreed that they were the most preferred method for adolescents because of their ability to protect against both pregnancy and STDs and also because they were cheap, more readily available and "convenient". Convenient was deduced to primarily mean that they could be accessed in shops or dispensaries and did not require visiting the health unit.

"If I organize for my lady and I to have sex I cannot arrange for her to go there to have an injection or get pills...it is saving time for me to just go there and get a condom, I can go to the shop and we can play sex." (male student)

Males were generally more confident that they could go to the health unit for assistance, if necessary, while females expressed fear of not being treated nicely by health workers or of being refused treatment altogether.

Facilitator: *"Why do you think you would be refused service (at the health unit)?"*

Participant 1: *"Because we are still young, Because they think we are not supposed to involve ourselves in these things."* (female student)

Participant 2: *"They (the health workers) think we are befriending their men, because we are still young and pretty to men."* (female student)

When asked about receiving service at health units, most students seemed to think that health unit staff did not welcome young people, that staff were more interested in discovering who the sexual partner was than in providing service, or that staff would condemn students for being sexually active. However, the greatest deterrent to the use of health centre services by both male and female participants was the sense of a lack of privacy and confidentiality. There was a general fear that health workers would tell others, particularly teachers or parents.

“Girls at this end do not go to this health unit because they fear to go there because they will tell other people, maybe they will tell our parents or the teachers here at the school.” (female student)

“If you go to the health unit and it is for you but you say someone else has sent you. They will ask you and you don’t want to be identified because after that they will be able to tell other people that you came for condoms. These are the issues so you prefer to go to shops.” (male student)

“The big fear is that the health worker will reveal everything to the parents. We fear going to the health unit because of the parents. Maybe the parents will see the boy or girl going to the health unit, we do not trust.” (female student)

The inability to trust health workers was reiterated by a female secretary who made the following comment during a school presentation about family planning:

“The confidentiality issue is even more important if the partner is not responsible. Women want to come (to the health unit) in secret but sometimes the man learns from health unit staff that his partner is using family planning. When the man learns this, he may assume that she is having an affair and there may be big problems.” (school support staff, female)

7.2.3 Elements of Youth Friendly Services are Quickly Identified by Adolescents

No participants reported to have accessed a CBD Volunteer for services and most had never heard of the CBD program. Adolescents agreed that the CBD program was a good concept but they appeared reluctant to see it as a service that could benefit them. Main reasons cited for this were fear of not being welcomed by CBD Volunteers, fear of lack of privacy and confidentiality and an inability to communicate openly with CBDs who are older.

Students overwhelmingly supported the idea of having properly trained CBD Volunteers who are “age mates” or peers, particularly if they could be directly involved in the selection of these peer educators.

“If we could participate in the selection of the person this would be good. And that the people we select would be trained really really well. If we can select someone that we can trust and then these people are trained, people would use this service.” (female student)

The majority of students felt that family planning services should be free or very cheap for adolescents and that the service provider should be readily available in locations appropriate and convenient for adolescents such as school grounds and town trading centers. Most agreed that house-to-house service would not be appropriate for adolescents since they would fear their parents presence as well as being seen entering the house of the family planning worker.

When asked what type of person they would choose if given the responsibility of selecting peer CBD Volunteers or family planning service providers, students were primarily concerned with having someone they could trust, someone who values confidentiality and can keep secrets. Males preferred this person to be male while females wanted other females to be available. Other preferred characteristics included good communication skills, friendliness, high moral standing and the ability to communicate both in English as well as local languages.

“Someone who is having the face of welcome. When you feel free to talk, the words flow out. Someone who is direct. Not someone that if she wants to tell you something and she first goes into corners without telling you directly what you want to know” (female student)

“The person has to be clever and not shy” (female student)

“We need someone with both languages because sometimes we are a little more shy in our local language, some words are not explicit enough or maybe there is a word in the local language but you fear to say it.” (female student)

“Someone who is near to me, who is easily seen... someone who is not harsh to people...and he must be well disciplined.” (male student)

CHAPTER 8 – DISCUSSION AND RECOMMENDATIONS

This discussion chapter has been divided into three sections corresponding to the three main research questions: 1) What are community perceptions of, and experiences with, the CBD family planning program in Kabarole? 2) Based on these local perspectives, what are the reasons for the constrained impact of CBD in Kabarole? 3) How can these perspectives be incorporated into suggestions for strengthening the CBD program?

8.1 Community Perceptions of, and Experiences With, the CBD Family Planning Program in Kabarole

Community perceptions are examined for three main areas: characteristics of CBD service providers and CBD clients, services provided and received and adolescents' perceptions and experiences.

8.1.1 Characteristics of CBD Service Providers and CBD Clients

According to questionnaire results, CBD Volunteers do not differ dramatically from clients in terms of socio-demographic factors such as tribe, religion, education, occupation, marital status or number of children. However, the median age of CBD Volunteers was found to be almost ten years higher than that of clients. This finding may be cause for optimism since it is consistent with the finding in a global review of CBD projects that the most successful workers tend to be older women (Bertrand et al, 1993). On the other hand, it may also serve as a cause for concern given that some respondents expressed worry that the older age of CBD Volunteers may encumber their ability to communicate with, and serve, adolescents. Another question also arises: are CBD Volunteers who do not use family planning, because they are post-menopausal or of "advanced age", effective role models for encouraging family planning use? Speculations regarding the significance of age can only be confirmed with further investigation.

Corresponding to the more concerted effort in Africa to recruit males as CBD workers (Population Council, 1998), more male CBD Volunteers have been recruited and trained in the Kabarole CBD program in the last two years. Twenty-five of the 70 CBD Volunteers completing questionnaires were males. Evidence from Kenyan CBD programs indicates that male agents tend to provide more condoms whereas female agents tend to provide more pills (Barnett, 1999b). This study found that both male and female CBD Volunteers provide primarily oral contraceptives to primarily female clients.

Both qualitative and quantitative results lead to the conclusion that willingness to do CBD work without pay may be the most important criteria for selecting CBD Volunteers -- as one Local Council leader put it “*we selected CBDs who have courage to serve others because it is a voluntary service.*” Other research has similarly concluded that selection of distributors should be based on willingness to participate rather than on social or demographic characteristics (Bertrand et al, 1993; Osborne and Reinke, 1981; Barnett, 1999b).

Seventy per cent of CBD Volunteers reported to use family planning. While it is certainly a positive finding that many CBD Volunteers “practice what they preach,” it should also be noted that 22.9% reported to use a method (Depo-Provera injections) that they do not and cannot provide to their clients. The impact of this is unclear. Optimistically, CBD Volunteers who are satisfied with their personal use of injections will utilize the appropriate, established referral channels to ensure that clients who prefer injections can access them.

Forty-seven of the 49 client respondents were using oral contraceptives. Only one male condom-user was available to answer the questionnaire. CBD Volunteer’s knowledge of the instructions they should give to clients to ensure correct condom use was impressive with 87% able to recite correct and comprehensive instructions that had been included in their training. CBD Volunteer monthly reports indicate that they distribute a substantial number of condoms every month though records do not indicate the sex or age of the recipients. Many respondents expressed their awareness that condoms were the most effective way to prevent sexually transmitted infections, particularly HIV/AIDS. Condoms, however, do not appear to be strongly perceived or promoted by CBD Volunteers as a family planning method or as a method that necessarily merits promotion with the majority of their clientele, married women. A recently published study from the Rakai district of Uganda found that current condom use is primarily motivated by the desire to prevent HIV/AIDS transmission, not to prevent pregnancy (Lutalo et al, 2000). They also noted that condoms were more often used by younger and unmarried, not married, men and women and among those who report multiple partners or extramarital partners (Lutalo et al, 2000).

Evidence from focus group discussions and interviews indicate that it is possible that CBD Volunteers make negative associations with condom use. Although not substantiated from this study (and deserving of future investigation), CBD Volunteers in Kabarole may share similar assumptions or perceptions about condoms as those recently reported in Kenya i.e. that people do not use condoms within marriage, that women are not in a position to refuse their partners sex

even if they perceive a risk of acquiring sexually transmitted infections or HIV or that condoms are clear symbols of promiscuity, infidelity and immorality (Bauni and Obonyo Jarabi, 2000). A study on contraceptive use in the Rakai District of Uganda found that men in Rakai, as is common in African surveys, report condom use more frequently than women and “that this is thought to be attributable to men’s use of condoms with extramarital partners” (Lutalo et al, 2000, p 219).

Although client respondents had been using their family planning method for a wide range of months, from two to 84, the median number of months was eight. 81.3% had been using their method for one year or less. This is a clear indication that CBD Volunteers need to gear their services towards helping active clients to continue use and to improve the effectiveness of their contraceptive practice. Because contraceptive use is still low in Kabarole, however, the CBD program must also aim to promote and encourage the adoption of modern methods among potential clients. In some countries of Asia and Latin America, where contraceptive use is already high, providers can be preoccupied with urging clients to continue use. However, a dual concentration on both present and potential clients is necessitated by the fact that in Kabarole, as in sub-Saharan Africa in general, current use and unmet need appear to be rising simultaneously (Westoff and Bankole, 2000).

Clients reported to have an average of four children. Whereas 51% said they wanted one, two or three more children, 46.9% said they did not want to have any more children. Results show that half of CBD clients participating in this study are using family planning to space births and approximately half are using family planning to limit births. This varies from the generalization reported in the literature that in sub-Saharan Africa, with few exceptions, contraceptive use has been adopted mainly to space births (Westoff and Bankole, 2000). Research examining the trends in the demand for family limitations in 41 developing countries does report, however, that Uganda is showing an “emerging momentum” towards the smaller family transition (Westoff and Bankole, 2000). Perhaps more importantly, this finding raises an important reminder that clients using family planning to limit births in Kabarole - particularly in light of the fact that 44.8% of client respondents already had between five and ten children - should be counseled on permanent contraceptive methods and referred if desires for permanent methods are discovered.

8.1.2 Services Provided and Received

Participants demonstrated an overall positive attitude towards family planning and the CBD program. While clarifying that more effort was needed, participants expressed satisfaction and pride that family planning had already improved the living conditions of families in the villages. They pointed to the improved physical and psychological health of women who are able to space and limit births and to the enhanced ability of families to care for existing children. Local leaders and CBD trainers credited CBD Volunteers with increasing women's awareness and willingness to accept family planning as well as their access to contraceptives. However, participants also cited social and economic changes in Kabarole as reasons for people's increased acceptance of family planning. These factors included the AIDS epidemic, poverty, underdevelopment, increased competition for resources such as land and government pressure for population control. The reason most often mentioned for the increased popularity of family planning was the present-day expense of raising children. The rising costs of educating children, i.e. paying school fees, appeared to be the predominant concern. While this finding contradicts Westoff and Bankole's statement that contraceptive use in sub-Saharan Africa is motivated principally by considerations of maternal and child health rather than by socioeconomic forces (Westoff and Bankole, 2000), it is precisely what Wolff et al found in their description of the nature of the decision to stop childbearing in Uganda (Wolff et al, 2000). They report that economic considerations were most frequently cited as the main reason for wanting no more children and that both men and women frequently mentioned the importance of education and the cost of school fees (Wolff et al, 2000). Agyei and Migadde, in their analysis of the demographic and sociocultural factors influencing contraceptive use in Uganda, also state that, given the difficult economic conditions in Uganda, families are likely to begin feeling the pressure of too many children once they have three or more surviving children (Agyei and Migadde, 1995). Research on the causes of fertility decline in Bangladesh similarly concludes that, while family planning programs have played an important role in reducing family size, socioeconomic changes, particularly the increased costs of raising and educating children, have minimized the benefits of large families (Caldwell and Barkat-e-Khuda, 2000). While it certainly cannot yet be said that families in Kabarole have made the "quality-quantity trade-off" – adopting contraception to have fewer children in hopes of giving those children better opportunities, as is evident in higher socioeconomic classes of some African countries as well as in Latin America, results from this study indicate that even in the rural district of Kabarole, change may be moving more in that direction (Bertrand et al, 1999).

Clients keenly expressed their satisfaction with the CBD program and the work of CBD Volunteers. The average satisfaction score, based on clients' responses to five satisfaction-related questions, was 4.49 (ranging from three to five). While acknowledging the potential biases in client selection as well as the limitations inherent in relying only on questionnaire data, as discussed in depth in chapter nine, clients appeared pleased with the services they were receiving and were able to articulate precise reasons for their contentment. For example, 98% of clients not only said no when asked if, given the opportunity, they would like to go elsewhere for family planning services but also offered justifications for their negative responses. Accessibility, availability, good education and counselling, continuity, good interpersonal relations and free services were some of the reasons shared by clients. Similarly, clients were able to verbalize, in their own words and with their own examples, what they liked best about the CBD program. In addition to the reasons listed above, clients also liked that the CBD program enabled them to space, limit and plan pregnancies and enjoy better personal and family health. They also noted that the CBD program contributed to the increased community acceptance and awareness of the benefits of family planning.

Client's willingness and ability to express their satisfaction with services is important for two reasons. First, that clients do not want to go elsewhere for service and can qualify why they feel this way may serve as a sign that CBD may be "considered by the majority of its acceptors not as a second rate approach but as their ideal way of obtaining services and reliable information" (Bouzidi and Fischer, 1991, p 7). Second, client's comments - no matter how eloquently or awkwardly expressed - regarding why they like the program and why they do not want to go elsewhere for family planning services illustrate that they can, and do, discriminate between varying standards of care. Though not asked directly to identify what they perceived to be good or bad quality in the care they received from CBD Volunteers, previously identified elements of quality of care arose. Their seemingly candid responses to open-ended questions demonstrate that poor, rural women can indeed articulate their preferences for care as long as questions are asked in ways they can understand. Despite on-going contention by some researchers that developing world clients may be unable to identify or judge quality indicators because of their limited experience, options and expectations (Koenig et al, 2000), quality of care investigators in various countries including India, Bangladesh and Chile have discovered the reverse (Schuler and Hossain, 1998; Vera, 1993; Simmons and Elias, 1994; Koenig et al, 2000, Whittaker et al, 1996; Simons et al, 1988). While Schuler and Hossain point out that in order "to hear women's voices, one must ask questions in ways that encourage them to speak" (Schuler and Hossain, 1998),

Whittaker et al reminds us of the importance of grounding the collection and analysis of clients comments about quality and satisfaction in the sociocultural and linguistic context of the respondent – and not in the western standards of the researcher (Whittaker et al, 1996, p 407).

Notwithstanding the possibilities of varying standards of care and concepts of health care, study results do not indicate glaring inadequacies in the quality of family planning services offered by CBD Volunteers. An examination of some of the elements of quality of care outlined in the Bruce Framework, such as choice of methods, information given to clients, technical competence and interpersonal relations (Bruce, 1990), suggests that, while there is certainly room for improvement, services are at least satisfactory. Acknowledging that efforts to measure and quantify quality components in non-clinical and community based distribution remain underdeveloped (Whittaker et al, 1996), Bruce's elements can serve as a gauge for the quality of services offered by CBD Volunteers.

Though CBD Volunteers are limited to providing oral contraceptives, condoms and foam tablets, they still appear to discuss a range of methods with their clients. When asked which family planning methods they discuss with new clients, CBD Volunteers listed an average of six different methods. 68.6% reported to discuss five, six or seven methods with their clients. This was confirmed by clients who, when asked which methods their CBD Volunteer had told them about, listed an average of four methods. 79.5% of clients reported that they had been told about between three and six different types of methods. A study in Kenya (Finger, 1999c) found that CBD workers tended to emphasize methods they could offer over others but this does not appear to be the case in Kabarole. In fact, while both the majority of CBD Volunteers and clients reported to tell or to be told about pills, 85.7% of CBD Volunteers and 85.7% of clients also reported to tell or be told about injections, a method not distributed by CBD Volunteers. The specific reasons for CBD Volunteers' discussions about injections are unclear. It may be they have a personal preference for them (29.7% reported to use them) or because they are confident and comfortable in their ability to refer interested clients for injections. It may also be that CBD Volunteers view injections as appropriate alternatives for female clients experiencing opposition from their husbands since injections can more easily be used secretly. Covert use of contraceptives does appear to be a relevant issue in Kabarole with 78.6% of CBD Volunteers reporting that they have female clients who are using family planning in secret from their husbands. Focus group and interview results confirm that inability to communicate with spouse, fears to do so and subsequent secrecy are pertinent issues for many women. 85.7% of clients

reported that their husbands or partners were aware of their family planning use but this high number may be associated with client selection – the mere ability of female clients to present themselves at the health unit in order to participate in this research may in itself be an indicator of husband's knowledge and approval. It may also be related to the type of family planning method being used since it is generally perceived that oral contraceptives are harder to hide from those who may be opposed, including husbands and, in the case of adolescents, parents. Other studies in Uganda also report that women covertly practice contraception as a strategy to overcome perceived or anticipated partner opposition (Wolff et al, 2000).

The quality and quantity of information given to clients was also examined as a dimension of service quality. Clients do not appear dissatisfied with the information received. All (100%) of clients agreed that, when the CBD Volunteer explains something to them, she/he uses words that are clear and easy to understand. When asked what they liked best about the program or why they did not want to go elsewhere for services, many clients mentioned that they received good education, counselling, advice and information from CBD Volunteers.

The majority of clients also report to have been told about the possible side effects of the family planning method they are using, however, only 65.7% of CBD Volunteers mention that they discuss side effects with new clients. Given that over 65% of clients reported to experience or have experienced problems or side effects with their family planning method and only half said they had received helpful advice from the CBD Volunteer on how to deal with these problems, CBD Volunteers need to be reminded of the importance of discussing the expected side effects. An honest and forthcoming approach to discussions about side effects will allow clients to have a clearer understanding of what to expect and ensure that they will not discontinue use at the first signs of discomfort or apprehension. Another potential area of concern is that 24.5% of clients reported that their CBD Volunteer had never talked to them about STDs, HIV/AIDS. That said, however, many clients (85.7%) answered correctly that their family planning method (pills) was not effective in preventing STDs.

Both clients and CBD Volunteers reported that CBD Volunteers generally talk about other health topics besides family planning such as nutrition, breastfeeding, immunization, hygiene and sanitation. These topics are not included in the initial training curriculum for CBD Volunteers. Discussions about other health topics may be facilitated by the fact that 35.7% of CBD Volunteer respondents also deliver other health services besides family planning such as immunizations,

tuberculosis drugs (Direct Observed Therapy Short-course, DOTS) and anti-malarials (chloroquine). At least two CBD Volunteers also had experience as traditional birth attendants in their villages. Other studies of CBD activities in Africa have also found that many CBD agents spend time on issues that are not directly related to family planning (Population Council, 1998; Phillips et al, 1999). In Tanzania, for example, more than 20% of an agent's time was spent on informing and referring clients on reproductive health issues other than family planning (Population Council, 1998). Importantly, these activities are rarely reported in Tanzania (Population Council, 1998) and never formally reported in Kabarole. In the absence of reporting and recording of these additional activities, there is a danger of the productivity of CBD agents being under-reported and under-valued. As has been stated elsewhere, failing to consider the activities of CBD Volunteers beyond the number of clients served and the couple years of protection incurred will misrepresent CBD contributions to broader reproductive and community health (Population Council, 1998).

Although CBD Volunteers scored reasonably well (average score of 14.41 out of a possible 20 points) on five knowledge based questions (important issues to discuss with new clients, ensuring correct condom use, best time to begin using a new method, contraindications to oral contraceptive use and appropriate responses to side effects), some obvious weaknesses were apparent. For example, when asked about the distribution of oral contraceptives to women with heart problems, tuberculosis or high blood pressure, results indicate a misunderstanding that there is a "special" type of oral contraceptive pill available for such women. According to BHS staff, this confusion likely stems from the distinction made, during training, between progesterone only pills (POPs) and combined oral contraceptives (COCs). Such misunderstandings indicate the importance of keeping training content as clear and simple as possible. Likewise, Ferguson, who has served as a Reproductive Health Consultant in Kabarole, has also emphasized that "communication on advantages of family planning and how to put messages across in the context of low contraceptive prevalence rates and pro-natalist views is much more important than training on the difference between POPs and COCs" (Ferguson, 1998, p 22).

While trained and encouraged (via checklists written in both English and Rutooro) to discuss at least eight pertinent issues with new clients, CBD Volunteers recalled only an average of four issues. Important issues that were least mentioned by CBD Volunteers included asking clients about their past experience with family planning, telling clients when to come back for follow-up, asking clients about their reproductive goals (i.e. determining if the client's intentions are to limit

or space), discussing possible side effects with clients and explaining how the chosen method works in the body to prevent pregnancy. On a positive note, 85.7% mentioned the importance of telling clients how to use the contraceptives. These findings appear similar to those found in Kenya and Zimbabwe. Measurements of quality of care in both countries found that CBD agents place more emphasis on informing pill clients about its use and less on establishing a clients needs or discussing side effects and their management (Population Council, 1998). Conversely, however, while CBD agents in Kenya demonstrated low levels of knowledge of how clients should use condoms (Population Council, 1998), Kabarole CBD Volunteer's recall of instructions for ensuring correct condom use was impressive with 87% giving correct and comprehensive instructions.

Clients appeared to have positive perceptions of their interactions with CBD Volunteers. Only three of the 49 respondents reported having had difficulties accessing the CBD or contraceptive supplies. Clients, when asked why they would not like to go elsewhere for services, articulated good interpersonal relations, such as "she treats me well", "she is nice to me" and "she is friendly". A study of quality of care in Chile similarly concluded that cordial treatment, for example, "*being treated like a human being*", was prioritized by family planning clients (Vera, 1993). Hierarchical modes of interaction between client and provider as well as a lack of accountability to clients on the part of family planning service providers have been found to be commonplace in many developing countries including Bangladesh and India (Schuler and Hossain, 1998; AbouZahr et al, 1996; Koenig et al, 2000). While this aspect was not directly assessed in this study, CBD Volunteers, at times, clearly demonstrated their concern and compassion for their clients, particularly when discussing male opposition, the dearth of effective information, education and communication supplies to share with clients and the heavy burden of numerous, unplanned or unwanted pregnancies in their communities.

Another noteworthy characteristic is that of CBD Volunteer's reported commitment to remain involved in the program and their optimism that the CBD program was making a positive change to the health of people in their communities. When asked if they planned to remain active as CBD Volunteers for the next one year, for example, all Volunteers except one answered affirmatively. CBD Volunteers also highlighted some personal and positive consequences of being involved in the CBD program that were not initially anticipated by the researcher. Some CBD Volunteers reported, for example, that their popularity or prestige had increased as a result of being designated as a CBD Volunteer and others perceived more respect and recognition from

community members. Increased personal knowledge, skills, well-being and self-esteem were also mentioned by CBD Volunteers as pleasant, but unexpected, results of their participation in the CBD program.

8.1.3 The Experiences and Perceptions of Adolescents

When asked about the participation of adolescents in the CBD program, some CBD Volunteers and trainers as well as local leaders expressed obvious apprehension. While some seemed to assume that married women, not unmarried adolescents, were the primary targets of the CBD program, others stated that either they or the adolescents were shy or fearful about discussing sexuality and reproductive health issues. That half of the CBD Volunteers reported to have clients under 18 may serve as a clear indicator that more efforts are being made to reach adolescents. There may, however, still be the perception among some CBD Volunteers that youth, especially those who have never had a child, should not use family planning. Some clients concurred, 28.6% thought that adolescents in Kabarole should not use family planning. A common community misunderstanding discussed by participants is that providing adolescents with reproductive health information or services is synonymous with encouraging immorality and promiscuity. A recent study in Nakuru, Kenya, reported similar findings, stating “many people continue to believe that directing reproductive health initiatives to adolescents is tantamount to sanctioning nontraditional sexual behaviour” (Bauni and Obonyo Jarabi, 2000).

Results from focus group discussions in schools show that adolescent respondents were not aware of, nor being reached by, CBD Volunteers. Results also reveal that adolescents face numerous barriers to accessing family planning information and services. First, they lack specific information about how contraceptives and their bodies work. Participants shared an alarming number of misconceptions about modern contraceptives and expressed anxiety about the consequences of their use, particularly the use of oral contraceptives. An overly negative attitude towards condom use was not detected amongst adolescents though other investigators have reported a strong negative attitude towards condoms use amongst lay people in Uganda (Nuwaha et al, 1999; Agyei and Migadde, 1995) and amongst adolescents in the developing world in general (Friedman, 1994).

Second, adolescents complained of a lack of reliable and trusted sources of information. They expressed fear, particularly the fear of “losing school”, if they attempted to discuss or disclose their sexual activities to adults, parents, teachers and health professionals. Third, adolescents

perceived access and utilization barriers to receiving health care at clinics. They fear unwelcoming receptions or negative interactions with health care workers and assume an inability to trust them with their issues. The greatest deterrent to the use of health services, if services were perceived to be available at all, was the perception of a lack of privacy and confidentiality. These findings correspond to other examinations of the reproductive health care needs of adolescents from the developing world (Friedman, 1994; Newton, 2000) as well as from Kenya and Uganda (Bauni and Obonyo Jarabi, 2000; Hulton et al 2000).

Only four clients ever mentioned the importance of privacy when asked about their experiences with the CBD program. However, both male and female adolescents persistently expressed concerns over privacy and confidentiality. This serves as a reminder of the differences between the program priority areas of adolescents and older adults. Whereas accessibility and acceptability issues seem to be crucial for adult clients, confidentiality, and privacy and to be treated well by the service provider seem to be the priority areas for youth (Newton, 2000). Additionally, now that the Kabarole CBD program is consciously seeking out male clients, the gender differences between male and female counselling needs and approaches should be considered. A study from Kenya has recently highlighted some of these gender differences. For example, while males wanted information, females wanted to adopt a method. Men tended to express more worries than women. Also, providers were found to offer more detailed information and respond more supportively to men than to women (Kim et al, 2000).

Views of CBD Trainers and Volunteers and Local Council leaders, as well as reproductive health indicators for adolescents, strongly suggest that the barriers perceived by students in Kabarole are very real and significant. The level of adolescent pregnancy in Uganda is one of the highest in the world (Hulton et al, 2000). By age 18, more than half of female adolescents are mothers. This percentage rises to 64 percent by age 19. The 1995 UDHS reports that by age 15, almost one third of girls interviewed had experienced their first sexual intercourse (Hulton et al, 2000).

8.2 Participants' Perspectives on the Reasons for the Constrained Impact of the CBD Program

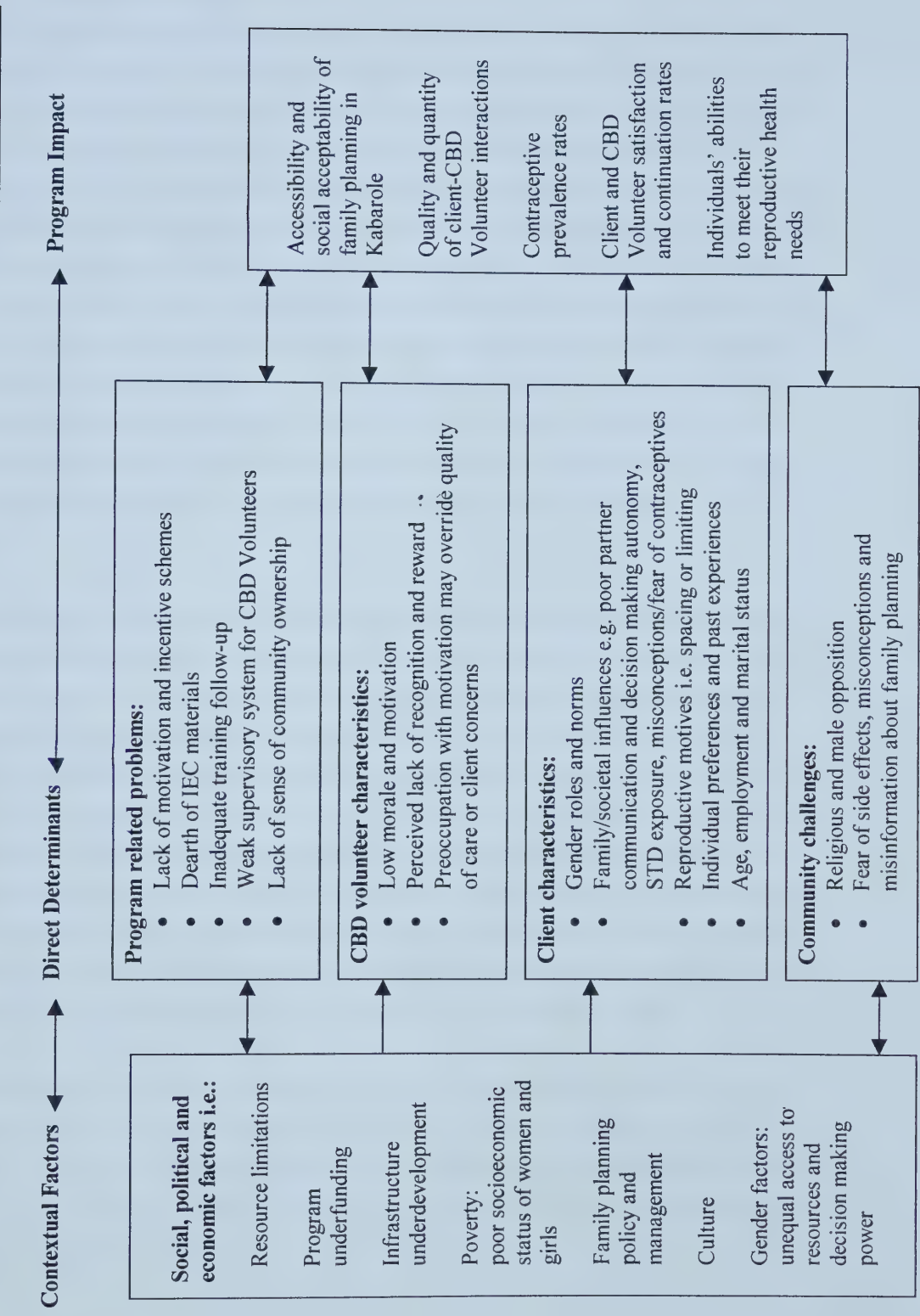
This discussion of participants' perspectives on CBD program obstacles or hindrances have been discussed in terms of four key areas: 1) a web of interactions of determinants, 2) community challenges, 3) program related problems and 4) preoccupations with morale and motivation - implications for quality of care.

8.2.1 A Web of Interactions of Determinants

Results undoubtedly imply that participants were supportive of family planning and enthusiastic about its prospects for healthier families and communities. However, participants' positive attitudes about family planning and the CBD program were tempered by discussions about community obstacles and program problems. Participants identified a web of complex, interactive and reinforcing program-related problems and community challenges affecting the performance of the CBD program in Kabarole. These multidimensional and multidirectional variables have been visually displayed in Figure 8.1.

This particular web of variables, though it describes participants' perspectives of the cultural, social and programmatic or program related factors specifically at play in Kabarole, shares many of the contextual factors and program determinants affecting client-provider interactions, quality of care as well as the impact family planning services have on women's lives that have been previously identified in the clinic-based family planning literature (Koenig et al, 2000; Koenig and Khan, 1999; Simmons et al, 1986; Simmons and Elias, 1994; Hong and Seltzer, 1998). The contributions of previously designed theoretical and conceptual frameworks, particularly those of Ruth Simmons, to the conceptualization presented in Figure 8.1 are therefore acknowledged.

Figure 8.1: Factors constraining CBD program impact in Kabarole, their determinants and program impact



8.2.2 Community Challenges

Both quantitative and qualitative results imply that participants' perspectives of the greatest community challenges to family planning acceptance and subsequently, CBD utilization, include opposition from men or husbands and religious leaders and the abundance of misconceptions and fear surrounding contraceptive use. These obstacles have been reported elsewhere in the literature. In a 1991 review of community based family planning services in Africa, authors noted that opposition from men/husbands, desire for more children (primarily on the part of men) and religious opposition (perceived or real) are very real obstacles to acceptance of family planning (Bouzidi and Fischer, 1991). A recent study of the trends in the demand for family planning also concludes "Women in sub-Saharan Africa have identified the opposition of others (especially husbands) to contraceptive use and fear of side effects as the main reasons for not practicing contraception" (Westoff and Bankole, 2000). Perceptions of religious opposition in Kabarole ranged from assumptions or beliefs that the church equates family planning with the killing of children to blatant examples of the discriminatory treatment of CBD Volunteers by church leaders.

Though opposition was most often articulated as coming from "the church" or "the religious", participants most often specifically mentioned the Catholics or the Bisaka when requested to clarify. While the Catholic Church's opposition to family planning is a commonplace notion worldwide, Ferguson has previously reported that the Catholic Church, which has a strong presence in Kabarole, is not perceived as being as vehemently opposed to family planning as the smaller fundamentalist religious sects (Ferguson, 1998). The difference in findings here may be attributable to differences in sources. *While this study* relies primarily on the perspectives of those at the grassroots level i.e. clients, CBD Volunteers, Trainers and sub-county local leaders, Ferguson may have relied more on program managers at the district level. Other unpublished studies from Kabarole specify religious opposition and single out the Catholic Church as the one that discourages use of contraceptives (Baryomunsi, 2000; Bajenja et al, 1998).

It should be noted that, during questionnaires, religious opposition was mentioned much more frequently by CBD Volunteers (88.7%) than by clients (10.2%). This difference may be attributed to the fact that CBD Volunteers are more visible and more easily identifiable than their client peers. The higher profile and popularity of CBD Volunteers may make them easier targets for opposition or harassment.

Many participants expressed the perception that, while men's opposition is less than it was in the past, men continue to act as barriers to contraceptive access and acceptability for women who want to stop or limit childbearing. Some participants attributed male opposition to their desire for more children or to traditional pronatalist cultural views, others credited it to gender inequalities in decision making i.e. the predomination of men over family decisions and to the initial exclusion of men in the early family planning initiatives in Kabarole. Participants from focus group discussions and interviews revealed that there are potentially high social costs for women raising the issue of family planning with men, particularly fears of being perceived as unfaithful or that the men will go elsewhere. These findings of community challenges are consistent with other studies in Uganda that examine the determinants affecting contraceptive acceptance (Wolff et al, 2000; Lutalo et al, 2000; Agyei and Migadde, 1995; Blanc et al, 1996).

While men and husbands were perceived as real threats to family planning acceptance, participants' comments also conveyed an optimism that men could be more supportive with intensive community education and increased efforts to encourage men to participate. Kaida's investigation into the knowledge, attitudes and practices of married men in Mpigi, Uganda supports this optimism (Kaida, 2001). She concludes that men play an important role in the decision to use family planning and that men want to be involved in family planning but require increased information and services in order to do so (Kaida, 2001).

It is impossible to confirm from this study if male opposition in Kabarole is as real as it is perceived. On the one hand, the perception vs. reality dichotomy may not matter. Women's perceptions of their husband's disapproval have been found to determine their disuse or secret use, when in fact the husbands themselves report that they approve. Conversely, studies have also shown that when husbands approve or when wives *think* that husbands support it, the wives are more likely to use contraception (Robey and Drennan, 1998). On the other hand, investigations into male participation in family planning point to the importance of relying less on common perceptions, assumptions and stereotypes about men's disinterest and ignorance and more on substantiated facts about their knowledge, positive attitudes and approval. Although male attitudes and practices vary enormously from one setting to another within Africa, accumulating evidence suggests not only that more men approve of family planning than previously thought but also that many more males would participate if given the opportunity to do so (Robey and Drennan, 1998).

Ferguson reported in 1998 that, in Kabarole, “rumours abound about the imagined results of using hormonal methods and that health unit staff and CBDs were woefully equipped to counter these rumours” (Ferguson, 1998, p 5). Results from this present study imply that this situation has not changed much over the years. Participants articulated that fears over contraceptive side effects and a seemingly endless array of rumours, misinformation and misconceptions about the possible physical repercussions of using contraceptives are major deterrents to family planning acceptance. Commonly cited rumours were that contraceptive users would become permanently infertile or produce deformed babies and that pill users would become overweight.* Focus groups and interviews with both adults and adolescents also revealed a common perception that contraceptives could make users, particularly women, weak or sick and therefore unable to work - a vital prerequisite for survival in this poor, agricultural setting. Similar rumours and misconceptions about family planning methods and their role in deterring use have been reported in an unpublished Knowledge, Attitude and Practice study done in Kabarole in 1998 (Bajenja et al, 1998) as well as published reports from other districts in Uganda (Kaida, 2001; Rutakumwa, 2000; Hulton et al, 2000). Optimistically, questionnaire results found that 77.6% of clients did not believe that contraceptives could make a woman weak or decrease her health. The majority of clients also felt that giving birth was more dangerous than using family planning.

8.2.3 Program Related Problems

Results from questionnaires with CBD Volunteers as well as from interviews and focus group discussions indicate that the issue of motivation or facilitation dominated the program related problems faced by CBD Volunteers. Lack of rewards, incentives, allowances or remuneration for CBD Volunteers was perceived to be the greatest program predicament. That motivating CBD staff, particularly if they are voluntary workers, is one of the greatest challenge to sustaining CBD program impact has been echoed in literature on CBD programs in Africa and elsewhere in the developing world (Evans and Huezo, 1997; Population Council, 1998; Phillips et al, 1999; Finger, 1999c). This problem has also been previously identified in Kabarole (Ferguson, 1998; Baryomunsi, 2000).

* It is interesting to note that, in Kenya, the more common rumour is that contraceptive pills cause women to become thin (presentation by A. Kaler, April 9, 2001).

As previously noted in the results section, remuneration referred to the need of CBD Volunteers to receive modest cash allowances for lunch or travel and non-monetary rewards or incentives such as lunch, soap or salt, not salaries. The humility of such requests is amplified when one considers CBD Volunteer reports of their time commitment. Questionnaire results, for example, found that CBD Volunteers report to spend a median of eight and a half hours per week on CBD activities and that they report requiring a median of 90 minutes to walk to the health unit at the sub-county level for their monthly reporting meetings with the CBD Trainer. Considering the long travel distances, in combination with complaints about lack of protective wear in the rainy season and the lack of rewards (“*not even a bar of soap*”) or recognition, it is hardly surprising that CBD Volunteers compare their roles to the futility of “*chasing the sun*”. Despite the volunteer status of the CBD agents, most participants, particularly local leaders and CBD Trainers, expressed sympathy and understanding both for the high frustration and low morale of CBD workers as well as the overall resource constraints at the program and Local Council level. Complaints about the lack of remuneration and rewards for CBD Volunteers seemed to originate from recognition of the prevailing low socioeconomic conditions in Kabarole. Like the clients they serve, most CBD Volunteers live in poverty, are overburdened with multiple commitments and the daily struggle for survival and are often unable to meet the basic needs of their families. Considering the context, the urgency with which participants described the importance of CBD Volunteers receiving support for their income generating or credit and savings activities in the absence of other financial incentives, and their disappointment that support is not forthcoming, is understandable.

CBD Volunteers’ inability to reap even meager financial benefits from their work was suspected of contributing to ridicule from other community members, particularly women, and to blatant opposition or perceived lack of support from the spouses of some CBD Volunteers. A perceived lack of support or acknowledgement from program managers and local community leaders, in combination with broken promises and the sense that previously articulated problems were not being adequately recognized or addressed, further aggravated CBD frustration and disappointment. Some CBD Volunteers also expressed frustration in not being able to meet the family planning needs of clients because their methods were restricted to pills, condoms and foam tablets and did not include injections.

According to participants other noticeably weak CBD program components include the dearth of IEC materials, lack of follow-up training or refreshers and lack of field visits and supervision.

Lack of training and poor field support were provided as reasons for CBD Volunteers inability to access many adolescent clients. Program components never or very rarely mentioned as being problematic in Kabarole -- but typically identified in the CBD literature -- include the referral system, consistent contraceptive supply, selection of CBD Volunteers or quality of care (Evans and Huezo, 1997; World Health Organization, 1997; Phillips et al, 1999; Osborn and Reinke, 1981).

Discussions about programmatic weaknesses illuminated participants' perceptions on the ownership, or lack thereof, of the CBD program. Despite efforts to include community council leaders in the program, particularly in the referral and selection of CBD Volunteers, a sense of community ownership for the CBD program was not evident amongst the participants. Most participants expressed frustration that the Local Councils at the sub-county level did not or were not able to provide more financial support. However, the majority seemed to feel that the implementation and success of the CBD program, since it had been initiated by Basic Health Services (BHS) via German Technical Cooperation (GTZ), was the ultimate financial responsibility of BHS and GTZ, not Local Councils or district health. This perception was also identified in information gathering interviews with both BHS staff (paid by GTZ) and District health staff (paid by the District Management Team). This was previously recognized by Ferguson who noted a tendency for Ministry of Health counterparts to perceive CBD as a BHS Project function rather than a district function (Ferguson, 1998). This dichotomy between BHS/GTZ staff and Ministry of Health or district staff is disconcerting considering the imminent departure of GTZ at the end of 2001 and the supposition that CBD program responsibilities will automatically and fruitfully fall to the district public health nurses. This "us" vs. "them" mentality of district and BHS staff, apparent at present, will not be conducive to an effective handover of CBD program priorities, responsibilities or programmatic memory. Immediate strategies, involving management, field staff, CBD Trainers and CBD Volunteers, are needed for building and increasing commitment to the CBD program and for ensuring that the CBD program will be integrated in a sustainable fashion into the portfolio of district health activities. Related to this is the need for a pertinent reminder to staff that a major factor often contributing to the failure of CBD programs is misplaced faith in CBD success (Phillips et al, 1999). If the CBD program is viewed by management staff as something simple to manage and automatically successful just because it relies on volunteers and a small budget, the basic elements of service quality and sound management will likely be neglected (Phillips et al, 1999).

8.2.4 Preoccupations with Morale and Motivation: Implications for Quality of Care

The urgency of improving quality of care and providing client-focused services have dominated the family planning literature and seemingly permeated family planning programs since the 1994 International Conference on Population and Development in Cairo. Such deliberations, however, did not appear pervasive in Kabarole. Participant perspectives and perceptions indicate that the CBD program is, by necessity, more CBD Volunteer-oriented than client-oriented at present. Community and program related factors served as the overriding concerns for the majority of participants and dominated the discussions, leaving quality of care issues relatively unscathed. The present preoccupation with empty stomachs, albeit legitimate, compromises the potential for nurturing a client-centered approach or a focus on client-provider interactions. Quality of care cannot be adequately tackled while issues of motivation and morale remain unaddressed.

This finding illuminates a number of pertinent issues regarding quality of care that should be acknowledged and advocated by CBD program managers, particularly those who presume that quantity must be prioritized over quality in low resource settings. First, CBD service quality and quantity often work in a feedback or cyclical fashion. In Kabarole, for example, program components, structure and management, coupled with community constraints, affect not only the quantity but also the quality of the services provided by CBD Volunteers (Whittaker et al, 1996). Just as low motivation or morale can serve as determinants of fewer and poorer quality CBD-client interactions, program efforts to improve the policy, managerial or structural context of CBD service delivery can translate into improved quantity and quality of client-provider interactions (Simons and Elias, 1994).

Second, when the interaction between quality and quantity is acknowledged, CBD program managers should not feel obliged to choose between allocating resources to more services (greater access) versus better services (quality) (Bertrand et al, 1995). Instead, they can endorse strategies aimed at enhancing both access and quality concurrently (Bertrand et al, 1995). As Bertrand et al write, “although some amount of tradeoff may be inevitable between increasing access and improving quality, in many instances having to strike a balance between such alternatives can benefit both” (Bertrand et al, 1995, p 68).

If forced to choose the most cost effective option, however, international experts advise a primary, initial concentration on quality of services provided to already existing clients (i.e. keeping active clients happy) followed by the secondary objective of recruiting new clients or increasing the quantity of services provided (Kipp, 2001).

Given the resource constraints of BHS and the tendency to consider CBD program output and impact in quantitative terms (such as number of clients, couple-years of protection and contraceptive prevalence rates) the case for quality can be argued in quantitative as well as humanitarian terms (Bertrand et al, 1995). Improving the quality of services, while allowing clients to meet their reproductive needs, also affects their decisions to accept methods and their motivation to continue using it. As Bertrand et al note “it results in larger numbers of clients seeking out services and adopting contraceptive use in a sustained manner” (Bertrand et al, 1995, p 68-69).

A third general issue about quality of care is also noteworthy, particularly for program managers and donors who may be unsure of the universality of the concern for quality, especially in non-western, rural and low-income settings (Whittaker et al, 1996). Intended and achievable standards for quality of care cannot be externally imposed but rather, should be set within the local context of the individual CBD program by those responsible for delivering the family planning services. As Jain et al write “without the ingenuity and support of program managers, any international rhetoric about improving the quality of services would be but empty words” (Jain et al, 1992, p 392). As with program decisions regarding access or coverage, service providers, as well as those reliant on the services, should also be included in the standard setting process. At BHS, this process could include program managers, CBD Trainers, CBD Volunteers, community representatives and clients. The standard setting process should embrace both the technical and affective aspects of care, it should be a “continuous, evolving and dynamic effort to improve access and learn more from clients’ needs” (Jain et al, 1992, p 392).

8.3 Incorporating Community Perspectives into Suggestions for Strengthening the CBD Program

Recommendations for improving the CBD program are discussed in two sections: CBD Volunteer’s potential roles in alleviating community constraints and suggestions for strengthening the CBD program.

8.3.1 CBD Volunteers' Potential Roles in Alleviating Community Constraints

As indicated in the CBD literature, CBD Volunteers in Kabarole play a role in reducing the social barriers as well as the geographical barriers to family planning. By providing a convenient supply, CBD Volunteers are generating contraceptive use that may not otherwise occur.

Additionally, they transcend the conventional notions of supply (Simmons et al, 1988) by facilitating increased social acceptability and quality of family planning in Kabarole. According to participants' perspectives, and as proposed in the CBD literature, CBD Volunteers in Kabarole can and should play a more instrumental role in addressing religious and cultural barriers to family planning, reducing fears about contraceptives, educating about sexually transmitted diseases and mobilizing overall community support, particularly that of males.

CBD Volunteers, for example, appear well placed to encourage male participation and foster better communication between men and women in Kabarole about fertility issues. Ugandan authors have noted that, since one of the greatest hurdles to interspousal communication on sensitive topics such as family planning or STD prevention is bringing up the subject for the first time, service providers can play a useful role in introducing these topics in a public forum "where it is safe for couples to discuss them without invoking suspicion of infidelity or weakened commitment to the union"(Wolff et al, 2000, p 136). Public educational activities of the CBD program and CBD Volunteers initiation of discussion can therefore lower the social costs of couple discussion about, and use of, family planning. CBD Volunteers can play a crucial role in efforts that encourage men to desire fewer children and to support their wives' desire to use modern and effective contraceptives (Westoff and Bankole, 2000).

CBD Volunteers can also be more instrumental in increasing community awareness about sexually transmitted diseases and in reducing resistance to condom use, particularly condom use within marital unions. This is especially relevant given that barrier methods offering dual protection against unwelcome pregnancies and sexually transmitted infections (STIs) / HIV do not appear to be popular among married CBD clients. By promoting condom use, encouraging dual methods (i.e. a long acting method for contraception and a barrier method for preventing transmission of STIs) and serving as referral agents for reproductive health concerns, CBD Volunteers can help both men and women protect themselves from sexually transmitted infections and unwanted pregnancies. Ugandan findings from the Rakai district reveal that concerns that family planning promotion may be undermined by HIV initiatives are unfounded.

Authors conclude that family planning provision and condom promotion should be viewed as complementary rather than competitive (Lutalo et al, 2000).

In an effort to introduce female condoms to the population, samples were being sporadically distributed free of charge by BHS staff in Fall 2000. While the addition of more female controlled contraceptive methods, such as female condoms, to the repertoire of CBD Volunteers is ideally welcome, initial community feedback is not favourable. First, the price of female condoms (1500 Ugandan shillings for three versus 500 Ugandan shillings for three male condoms) may be prohibitive. Second, the female condom, though controlled by the female, still requires the knowledge and cooperation of male partners. Third, female condoms may be perceived to encumber traditional or culturally-specific sexual practices, particularly those surrounding foreplay. In-depth field-testing of female condoms and careful examination of the barriers to female condom use are essential before female condoms can be distributed by the CBD program.

CBD Volunteers indirect contribution to referrals should also not be underestimated. Considering the number of clients who report that they do not want more children as well as the perceived popularity of non-CBD distributed methods such as injections, the role of CBD Volunteers in counselling, motivating and referring can potentially be as important or even more important than the contraceptives they distribute.

While advocating CBD Volunteers' roles as STD/HIV educators and referral agents as well as their responsibilities to go beyond the traditional service population of married couples to reach men and adolescents (Finger, 1999b), caution is also advised with regard to expanding CBD services to include other reproductive health or primary health care services. While there may be a strong post-Cairo political consensus in favour of integrated reproductive health services and while a more holistic and integrated service approach would offer definite benefits to clients, increasing the service regimen of CBD Volunteers in Kabarole is questionable given the fragile delivery system at present (Reproductive Health Outlook, 2000). Critics agree that integrating services can overburden already unmotivated service providers, exacerbate existing problems and create new demands on every aspect of service delivery, including supplies and logistics, records systems, staff training and supervision (Reproductive Health Outlook, 2000). CBD Volunteers request training which would allow them to provide other services such as injections, however, a realistic concern may be that CBD Volunteers may pay less attention to family planning and quality of care issues when they become responsible for a host of new activities, especially if the

new activities offer the potential for generating much needed income. Such concerns should not be seen as a justification for outright rejection of integration, but rather as a programmatic issue that warrants attention and caution (Bertrand et al, 1995, p 69).

A recent study examining the experiences of four African countries (Ghana, Kenya, South Africa and Zambia) in implementing reproductive health integration policies found the process to be fraught with difficulties. It concluded that integration policies are particularly difficult to put into practice in low resource settings and within programs that have separate, differentiated programs instead of an all-encompassing primary health care approach (Mayhew et al, 2000). The Kabarole CBD program, although in principle incorporated into the overall primary health care approach of the Basic Health Services Project, appears in reality as a separate, differentiated program activity, in part due to the compartmentalized attitude of staff and the hierarchies of programs within BHS as well as within the district health services.

8.3.2 Suggestions for Strengthening the CBD Program

While there is agreement that CBD Volunteers can play significant and influential roles in alleviating the community challenges to increasing family planning use in Kabarole, participants also emphasized that CBD Volunteer potential cannot be fully realized until the noted program related problems are tackled.

Their suggestions for strengthening the CBD program included the following:

- Establish award, motivation and incentive schemes for CBD Volunteers.
- Support and facilitate their income generating and micro-credit initiatives.
- Prioritize community sensitization. Target religious leaders and males. Utilize drama, drumming and singing.
- Prioritize the education and service needs of adolescents – include them in program planning and implementation.
- Address weaknesses in supervision, follow-up training and educational materials.
- Increase the number of male and female CBD Volunteers.
- Listen to, and acknowledge, the goals and suggestions of CBD Volunteers.

Paramount to the improved impact and ensured sustainability of the CBD program is the establishment of incentive and reward schemes to increase CBD Volunteer motivation and morale. In light of the current financial constraints at BHS and the imminent withdrawal of GTZ

donor support, only non-monetary incentives should be considered at this time. Care must be taken to ensure that incentive schemes do not contribute to misreporting, aggressive recruitment tactics or an overriding concern for quantity of clients over quality of service. Ascertaining and including the opinions and suggestions of CBD Trainers, Volunteers and local leaders in incentive scheme design will greatly assist successful implementation. Local Councils, though also suffering severe resource restrictions, should be lobbied and provided with incentives to serve as more substantial supporters and advocates of the CBD program and the CBD Volunteers. Health unit staff, particularly Clinical Officers In Charge, if encouraged and backed by BHS staff, may be instrumental in efforts to lobby Local Councils to assume more responsibility for CBD program support and management. They have previously been found to be very influential advocates for immunization and malaria campaigns.

While an annual award for the best performing CBD group has recently been initiated in Kabarole, more frequently occurring contests and competitions offering higher incentives for better performance may serve to boost CBD Volunteer morale. As stated by the CBD Volunteers, small items such as soap, salt or lunch (particularly important for monthly meeting days) can serve as substantial tokens of appreciation. Although CBD Volunteers often prefer payment in cash instead of the provision of food, this often has negative consequences. First, CBD Volunteers simply go without food. Second, the practice of distributing project funds to CBD Volunteers sets an unsustainable precedent. This warning is repeated by Ferguson (based on his experience with the Kenyan CBD program) as well as by directors of other Kabarole-based community development organizations (Ferguson, 1998).

Participants offered a variety of other ideas for sustaining CBD Volunteer motivation including the provision of equipment such as bicycles, protective wear for use during the rainy season, uniforms and educational materials and facilitating study tours or exchange trips with other CBD programs in the country. Items such as bicycles and uniforms may assist with program logistical problems such as transport or ease community member's ability to identify CBD Volunteers. They may also assist to ensure an enhanced social status for the CBD Volunteers (Evans and Huezio, 1997). While CBD Volunteers reported increased popularity and social status as a result of being a CBD Volunteer, others reported experiencing ridicule from community members who perceived them as idle or nonproductive and complained of a lack of recognition on the part of community leaders and program organizers. Advertising CBD activities in local media sources such as newspapers and radio stations, encouraging CBD Volunteers to participate in high profile

events and family planning promotional activities and providing CBD Volunteers with opportunities to interact with health professionals are just a few innovative and inexpensive approaches to increasing CBD Volunteer social status. Special recognition of CBD Volunteers seems particularly fitting in 2001 since it has been officially designated the *International Year of the Volunteer*. This would provide a timely opportunity to acknowledge the valuable community contributions of CBD Volunteers without setting the unsustainable precedent for a yearly occurrence. Additionally, such an event may provide the first opportunity for all Kabarole CBD Volunteers to be together at the same time. Although seemingly insignificant, the physical presence of approximately 500 CBD Volunteers could be an empowering and encouraging way for CBD Volunteers to realize their collective efforts, influence and impact.

The CBD literature indicates that program financial sustainability can be facilitated with the introduction of user fees or fees for services (Evans and Huezo, 1997; Phillips et al, 1999; Ferguson, 1998). However, interviews and focus groups do not indicate that this is a viable option for the Kabarole CBD service at this time. The low acceptance and prevalence of contraceptives, the common notion amongst the population that family planning services should be free, the desperate economic conditions of the rural population as well as unsuccessful social marketing of contraceptives efforts in the early 1990s were cited as barriers to charging clients fees for services. At present, there is no mechanism in place to monitor if CBD Volunteers are receiving cash or in-kind contributions for their services. Clients completing questionnaires in this study seemed more willing to pay for services than initially anticipated by staff but further investigation into community opinions about user fees is required. Flexible fee scales may be an option (Williams et al, 2000) for Kabarole but a market study is needed to better understand client's willingness and ability to pay. The feasibility of an affordable, acceptable, community-negotiated client registration or annual membership fee could also be investigated (Evans and Huezo, 1997). Within Kabarole, there may be no harm in asking for payment for services rendered. Asking but not demanding, even if nothing is received or expected, may begin to ease clients' expectations or assumptions that family planning services should be free*. It may also encourage clients and community members to view CBD as high quality services worthy of payment, despite the fact that service providers are volunteers. Any cost recovery schemes must, of course, be based on the principle that no potential user of family planning would ever be prevented from using services for economic reasons. Additionally, while the CBD program priority should be low

* Ugandans are becoming accustomed to cost sharing for services received at health centers, however, official Ministry of Health policy is that contraceptives are provided free to the population.

income, economically marginalized populations, CBD Volunteers could be encouraged to market CBD services to higher income individuals, for example teachers, entrepreneurs or Local Council leaders, if available within the community.

According to study participants, sustainability of CBD Volunteer participation and commitment to continue the work as well as their willingness to attend monthly reporting meetings lies in program support for the income generating activities, micro-credit initiatives and small revolving loan funds of the CBD Volunteer groups. This does not necessarily entail start-up funds since cash payments, though often requested by CBD Volunteers, have proven to cause more harm than good when groups are not yet ready to handle them. However, there is a need to facilitate CBD Volunteer's access to information, assistance and potential sources of funds. This assistance is particularly crucial to those CBD groups that have already demonstrated a commitment to income generating activities. An exciting local prospect for this is the Kabarole Research Centre, a locally based non-governmental organization concerned primarily with supporting the micro- credit initiatives of organizations and women's groups in Kabarole. It was discovered, during an interview with representatives from the Kabarole Research Centre, that groups of CBD Volunteers might be eligible to receive assistance with their income generating initiatives. If CBD Volunteer groups are deemed not yet ready to receive an actual loan for their activities, the Kabarole Research Centre can work with them to assess community needs, ensure group cohesion, define long-term visions and goals and establish group constitutions and by-laws.

The availability of other micro-credit or credit and savings organizations in Uganda and opportunities for potential linkages should also be investigated since micro credit and income generating schemes (often in combination with health initiatives) are presently popular development approaches advocated by numerous international donors. It may also be possible to access already available training curriculums designed to build capacity in areas of business, accounting, income generating skills or credit and savings. Ideally, these training materials utilize self-teaching or participatory methodologies, are designed for semi-literate populations and are available within Uganda and Africa. Many already available training materials can be made culturally appropriate with minor modifications and the help of local artists and editors.

CBD program impact is also contingent on the prioritization of community sensitization, particularly the very real obstacle areas of male and religious opposition, community rumours, misconceptions and misinformation about the consequences of contraceptive use as well as fear

of side effects. Policy and program efforts to increase contraception adoption and continuation must be directed toward eliminating or at least mitigating these obstacles. Failure to address these potential social costs of family planning can be a major factor in the failure of the CBD program. CBD Volunteers can play crucial roles in alleviating these obstacles but not without support and assistance from program management. Study participants identified drama and drumming as effective mechanisms to deliver culturally appropriate family planning messages. Some CBD groups have already developed plays and songs proclaiming the benefits of family planning but lack the transport, musical equipment, costumes or organizational skills to offer their shows to the public on a large scale. Traditional media channels such as music, popular theatre, dance performances, puppet shows and comedy have proven highly effective for creating awareness of health issues in numerous developing countries (World Health Organization, 1997). These were also instrumental in educating the people of Kabarole about HIV/AIDS in the 1990s.

Many study participants asserted that the dearth of information, education and communication (IEC) materials was hindering their ability to further educate community members and themselves. CBD Volunteers and Trainers complained of never receiving the “Planning Your Family” flipcharts supposedly available for all CBD Volunteers. Another complaint was the total lack of written materials to accompany initial training sessions. Upon the completion of training, CBD Volunteers generally return to their villages with only the written notes they themselves have made during training. Given the poor levels of literacy amongst clients and CBD Volunteers, a comprehensive plan for the preparation and distribution of IEC materials (for Trainers, CBD Volunteers and clients) should be developed and approved as soon as possible.

In light of project financial constraints, cost-sharing and cost-cutting measures can be considered. The CBD program can, for example, rely more on culturally appropriate pictures, cartoons, posters or other visual displays that do not generate extensive translation costs. One possibility is to recruit local artists to create appropriate posters, scenarios and cartoons. Another may be to sponsor drawing or art contests in high schools, colleges and university departments. This can generate excellent posters, concepts and educational or promotional materials, especially if the students receive informational and educational sessions about family planning beforehand. Of course, all educational materials will require field testing and quality control to ensure that messages are culturally appropriate and appreciated. An investigation into the availability of African educational materials and potential sources for future materials may also be helpful. Additionally, many international family planning journals and published reproductive health

studies are often available free to organizations in the developing world and these may be appreciated by BHS staff and CBD Trainers.

Increased advertising and promotion about the CBD program and the availability of CBD Volunteers, particularly amongst adolescents, is also needed. Other BHS program field workers can be utilized to inform community members about the CBD program. As well, CBD Volunteers can be encouraged to form formal or informal volunteer coalitions with other grassroots workers in their areas who are involved in a variety of health initiatives such as tuberculosis, safe motherhood, immunization and malaria. Such collectives could facilitate the planning, advertising and success of joint community educational activities. Direct Observed Therapy Short-course (DOTS) distributors have already found this to be an effective strategy in a few parishes within Kabarole. Satisfied clients can also serve as very effective advertising agents for the CBD program – indeed it was very positive to find that 81.6% of clients reported to have recommended the CBD services to a friend or relative. CBD Volunteers can ask satisfied clients to assist them by recruiting new clients, recommending CBD services to others, telling others about their satisfaction or promoting family planning among adolescents whenever possible.

An abundance of rumours and misperceptions about contraceptive use was cited as a deterrent to family planning acceptance by many participants, including adolescents. A key message for IEC materials should be that contraceptives are safe and that the health benefits associated with contraceptive use clearly exceed the risks (World Health Organization, 1997). However, an honest and forthcoming approach to discussion about side effects is also crucial. It has been noted that failing to look at side effects as an issue is like “handing a weapon to those who are ethically or emotionally opposed to family planning” (Fischer and Bouzidi, 1991). One idea may be to initiate a frank discussion about the common community rumours during CBD Volunteer training sessions and have all participants, including staff and Volunteers, brainstorm on effective rebuttals to these rumours and misconceptions. Common rumours and corresponding responses could be written in the form of handbills or file cards for easy reference by CBD Volunteers (Ferguson, 1998; World Health Organization, 1997). Additionally, encouraging those directly or indirectly involved in the CBD program (i.e. RH staff, trainers, CBD Volunteers as well as local leaders) to question or think critically about unproven or unsubstantiated assumptions and responses (e.g. all community members fear side effects, all adolescents fear CBD Volunteers, all religious leaders oppose family planning) may prevent people from feeling overwhelmed, disempowered or complacent with the status quo.

Undoubtedly, many of the initiatives and suggestions described above require time and commitment from project staff. An alternative suggestion may be to utilize university students who come to Kabarole district to meet their requirements for field and research experience. This would require expanding the potential student base to include a variety of disciplines besides public health, for example, business, micro-credit, marketing, accounting, education and communication, community development, volunteer management, health policy and management, communication, education and graphic art and design.

In an effort to ease the religious opposition to family planning in the district, reproductive health staff organized a meeting of leaders from various faiths including Catholics, Anglicans and Muslims in 1999. Church leaders presented papers outlining official doctrine and positions on the issue of family planning and reproductive health staff were able to clarify their roles and rationales as family planning service providers. The meeting took place in an atmosphere of mutual support and recognition and religious officials expressed enthusiasm for future collaboration or at least, minimum condemnation of family planning initiatives. Unfortunately, and ostensibly due to lack of funds and time, a subsequent meeting has never been organized by CBD Program management. Arranging immediate follow-up to this meeting, if only in written form, will serve as a clear symbol of BHS commitment and priority to mitigate religious opposition experienced by clients and Volunteers of the CBD program. Additionally, further investigation into religious opposition may clarify if it is indeed as real as it is perceived. It would also help to clarify if religion is the real reason for people's unwillingness to practice contraception or if it is simply the pretext, "the vehicle through which people articulate high fertility norms or express ambivalence about fertility limitation" (Simmons et al, 1988, p 33).

Study participants infer that religious prohibitions, coupled with traditional moralist viewpoints, cultural beliefs, ignorance and male obstinacy contribute to the perception of male opposition and males lack of communication about family planning. Similar results have been reported in Kenya (Bauni and Obonyo Jarabi, 2000). The BHS CBD program has made strides in increasing the participation of males, particularly with regards to the recruitment and training of males as CBD Volunteers. However, encouraging male involvement and spousal communication about family planning must be a continual priority. Without the promotion of male involvement and education, males will continue to thwart efforts to encourage positive contraceptive decision-making. They will remain vulnerable to rumours and misinformation that have made them unsupportive of family planning practices (Bauni and Obonyo Jarabi, 2000). Information, education and

communication programs must address the existing sociocultural hindrances to spousal communication and decision making so as to counteract their effect on contraceptive use (Bauni and Obonyo Jarabi, 2000).

Study results indicate that increased training of CBD Volunteers can translate into increased quality of information provided to clients, such as the number of contraceptive methods mentioned during initial counselling of clients and CBD Volunteer's tendency to discuss side effects. As discovered in this study, an important area that should be highlighted during training of CBD Volunteers is the importance of being familiar with, and consulting, the checklist of important issues to discuss with clients before contraceptives are distributed. The distribution of a clear, colorful, user-friendly checklist may entice CBD Volunteers to refer to it more often. If made available in the format of a pull-out, handbill or cloth flip-charts, the checklist may encourage a more participatory dialogue between provider and client and increase the chances that pertinent family planning issues (such as reproductive goals, past experiences with contraceptives, follow-up and spousal communication) are discussed.

According to study participants, lack of refresher or follow-up to training was a bigger concern than the quality or intensity of the initial training session attended by all selected CBD Volunteers. The CBD literature confirms that training of CBD Volunteers generally works better when it is competency-based, incremental and practical and when initial training is followed up with periodic refresher courses (Bouzidi and Fischer, 1991). Incorporating Training of Trainers methodology, whereby CBD Trainers receive information via in-service thematic quarterly meetings or educational bulletins and newsletters and then share this information with CBD Volunteers during monthly reporting meetings, may prove helpful in increasing the quality and quantity of refresher training. Since bringing CBD Volunteers together for training is an expensive endeavour, another alternative may be to take training to the CBD Volunteers through a continuous approach that incorporates refresher training into ongoing supervision. This would, however, require strengthening of the present supervisory system and incentives for CBD Trainers whose CBD supervisory responsibilities are uncompensated and supplementary to their clinical nursing duties.

There is general agreement in the CBD literature that supervision of CBD Volunteers is essential for maintaining program quality and for motivating staff (Evans and Huezo, 1997). Additionally, CBD agents who are supervised more frequently tend to meet more clients (Finger, 1999c). Study

findings indicate two major problems with regards to the supervision of CBD Volunteers in Kabarole. First, documentation about supervisory experiences is non-existent. A review of reports and databases at BHS uncovered a complete lack of documentation about field supervision experiences or any evidence that supervisory visits take place. Although some CBD Volunteers have claimed for reimbursement of travel expenses ostensibly acquired for field supervision, there is no mechanism in place that documents the number or content of supervisory visits per month. The establishment of a basic reporting system, perhaps in the form of a supervisory checklist (Finger, 1999c) or a simple standardized report card would allow program management and CBD Trainers to monitor community findings and CBD Volunteer progress. Cash disbursements for supervisory expenses (i.e. petroleum) should be made contingent upon receipt of these basic report cards or checklists.

Second, at present, field supervision of CBD Volunteers performance is weak. CBD Volunteers complain that, at present, supervision and support offered by the CBD Trainers are not enough to meet their needs. CBD Trainers concurred that field supervision is inadequate primarily due to logistical and time constraints e.g. lack of motorcycles, vehicles or gas; poor road and weather conditions; expense and distance, large size of geographical area to be covered or lack of public transport etc. CBD Trainers and Local Council Leaders complained that either there were inadequate funds to cover the costs of field supervision or that the mechanisms that had been put into place to facilitate field supervision (e.g. provision of gas or motorcycles for health unit services) were not functioning effectively. One CBD Trainer, for example, stated that although her health unit had been provided with a motorcycle, she was not permitted to use it for CBD supervision. This may be directly attributed to a lack of ownership for the CBD program on the part of Clinical Officers and other health unit staff besides the CBD Trainer.

Utilizing full time, field-based district health staff to intermittently supervise CBD agents may be an alternative to relying on the already overworked sub-county clinic nurses. The possibility of delegating more monitoring and supervisory responsibilities to interested CBD Volunteers, local leaders or community members should also be examined. As has been discovered in the family planning literature, supervision can also have greater impact and meaning when the focus turns to *what* is provided instead of *how often* it is provided. A CBD family planning program in northeast Brazil has reported the cost effectiveness of reducing the frequency of routine supervision from monthly to quarterly when supervisory visits are primarily concerned with

productive and training activities instead of the routine collection of inventory and service statistics (Foreit and Foreit, 1984).

If provided in combination with training refreshers, supervisory visits in the community could potentially allow more regular evaluation of CBD performance, knowledge and practices. This in turn would allow for the immediate identification of strengths and weaknesses operating in the field and CBD Volunteers could be provided with immediate feedback about their performance. Potentially, CBD Volunteers could be classified according to the level of their performance (Finger, 1999a) and awarded accordingly, thereby offering an incentive to improve individual efforts.

Study results also illustrate the urgent need to prioritize the needs of adolescents for reproductive health education and services. Participants agreed that CBD Volunteers need training on how to reach youth and on the specific educational needs and priority areas of youth e.g. confidentiality, privacy and to be treated well by the service provider. Electing or appointing a “champion” for youth within each CBD group may go a long way to encourage youth friendly services (Newton, 2000). CBD Volunteers also need support, advice and assistance in addressing community and parental resistance and opposition to youth reproductive health education and services. Clarification and articulation of official national population and family planning policies regarding the basic human rights of adolescents (regardless of parity or marital status) to receive information and contraceptives may be an effective strategy for decreasing community disapproval. If CBD Volunteers cannot access adolescents directly they can certainly be instrumental in accessing and sensitizing the parents of the youth. CBD Volunteers may also be able to take a more active role in sensitizing owners and workers of shops or commercial establishments that dispense condoms of the importance of providing youth friendly services.

Adolescents in focus group discussions overwhelmingly supported the idea of recruiting and training peer CBD Volunteers and this idea of peer outreach and education should be seriously explored by program management. Since addressing young people’s reproductive health problems demands the use of multiple interventions in multiple settings (Newton, 2000), BHS should investigate potential sources of cooperation and collaboration with already established adolescent groups and initiatives. The UNFPA funded Program for Enhancing Adolescent Reproductive Life (PEARL) has been pilot tested in Kabarole and peer mobilizers have already been recruited and trained in three of the CBD program sites. Future PEARL activities have been

slated for more sub counties within Kabarole, including three more areas that already have CBD programs in place. This may serve as a potentially golden opportunity for networking and partnering. Perhaps most importantly, it must be remembered that adolescent respondents in Kabarole, similar to those in various developing countries, articulated their specific need and desire to be involved in program design, implementation, management and evaluation (Newton, 2000). An additional, though admittedly more challenging, reminder is that strategies for improving the reproductive health of youth must strive to go beyond the relatively simple issues of increasing access to information and services. Other, more complex, issues --such as girls' empowerment, socioeconomic vulnerabilities and unequal access to resources or boys' lack of responsibility for their sexual behaviours or cultural assumptions of manhood and power -- must also be tackled (Hulton et al, 2000).

CHAPTER 9 – STUDY STRENGTHS AND LIMITATIONS, LESSONS LEARNED, FUTURE RESEARCH DIRECTIONS AND CONCLUSION

9.1 Study Strengths and Limitations

9.1.1 Limitations

Despite the researcher's previous cross-cultural experiences in the developing world and conscious efforts to be keenly aware of the contextual sensitivities (Rothe, 1994b) potentially at play in Kabarole, fundamental differences between the participants and the researcher may have affected data collection and analysis and must therefore be acknowledged. The personal biases, ideologies, values and past experiences of the researcher undoubtedly influenced the ambiance and approach to research in the field. In this developing world context, however, differences in language, gender, culture, ethnicity and class, and the ability of these variables "to compound the complexity of power relations" (Kitts and Hatcher, 1996, p16) must also be identified as potential and influential sources of bias.

The potential role of interviewer bias should also be considered. It is possible that the research assistants administering client and CBD questionnaires differed in their data collection approaches, despite the standardized training received. Post-test results did not indicate negative ramifications of using male research assistants to administer questionnaires or facilitate focus group discussions with female participants. Basic Health Services staff and research assistants were confident that this was culturally acceptable and had not negatively influenced participant trust or response in the past.

Perhaps the study limitations most worthy of consideration are those related to the study objective of assessing client perspectives of, and experiences with, the CBD program. Ascertaining client perceptions and levels of satisfaction is crucial if efforts to improve family planning programs are going to lead to increased acceptance and sustainability. Client satisfaction plays a central role in translating access and quality into positive outcomes such as program sustainability and achievement of client's reproductive intentions (Williams et al, 2000). Indeed these were underlying premises of this research study. Accessing clients, measuring their satisfaction and gathering their perspectives, however, proved more challenging than initially anticipated. These challenges are described below.

Limited access to clients

The initial intention was for the researcher and her assistants to reach CBD Volunteers and their clients in their own home areas. However, after an assessment of the numerous challenges associated with this approach, it was decided to confine data collection to the sub-county health unit. Long distances, exorbitant fuel costs, dangerous or impassable roads in the rainy season, as well as the impossibility of overnight stays due to security concerns made it impracticable for the researcher to attempt to reach CBD Volunteers. Since communication with individual CBD Volunteers, who are geographically dispersed throughout the sub-county, is difficult and inefficient at best, it could have been possible to finally reach the home of one CBD Volunteer only to find her unavailable. Furthermore, in the event of accessing a CBD Volunteer, her small client base and large geographical catchment area may have hindered access to her clients or former clients.

Client confidentiality issues, however, as expressed by CBD Trainers and Volunteers, provided the greatest deterrent to collecting data in the villages. Since many clients access CBD family planning services in secret from other community and family members, particularly husbands, showing up and expecting to meet with clients would have been unethical and potentially dangerous for clients. Some CBD Volunteers admitted that even the mere presence of the family planning vehicle could arouse suspicion and fear amongst villagers, particularly those opposed to family planning. The ethical requirement and programmatic obligation of protecting client confidentiality, particularly clients who practice family planning secretly and may come to harm if their covert use is revealed, has been previously described in the literature (Simmons and Elias, 1994).

Simmons and Elias, in their review of methodological issues in examining client-provider interactions, concur that manifold and complex barriers have kept researchers, professionals, policy makers and even managers from ascertaining client perspectives or accessing the real conditions in which clients interact with service providers. They note that language and financial barriers, confidentiality issues, as well as physical, social and organizational distances that separate policy makers, managers and researchers from both clients and providers have been immense (Simmons and Elias, 1994).

Possible selection bias

Because of the logistical and socio-cultural difficulties involved in reaching clients, CBD Volunteers were relied upon to invite clients to attend their monthly reporting meeting at the sub-county health unit, the researcher's data collection setting. This may have led to a selection bias i.e. clients who were invited and willing to participate may be systematically different from those who did not participate, particularly with regards to their satisfaction with CBD service and CBD Volunteer performance or their perceived ability to articulate their experiences or present the CBD Volunteer in a positive light.

Overall client satisfaction was found to be high. It is difficult, however, to identify exact reasons for this satisfaction. Of course, it is possible that clients were really satisfied. They were, after all, able to specifically articulate their reasons for not wanting to go elsewhere and what they liked best about CBD services. Additionally, questionnaires with CBD Volunteers, while highlighting areas in need of improvement, were not indicative of appallingly poor technical competence.

The family planning literature has advanced several other plausible reasons to explain client's positive impression of the CBD program. First, clients may be prone to courtesy bias, wherein they may be reluctant to express negative opinions about services that they have received (Koenig 2000). Courtesy bias can involve the tendency of a research participant to respond as she believes the interviewers want her to respond or to provide a satisfactory picture of CBD agents as a courtesy and sign of respect to the worker (Whittaker et al, 1996; Simmons and Elias, 1994). This may be especially prevalent if study participants believe their answers will affect the way the CBD agent treats them in the future.

Second, clients, despite being of similar socioeconomic backgrounds to CBD Volunteers, may perceive themselves as being less educated than CBD Volunteers, especially regarding reproductive health knowledge, and may therefore feel unable or unwilling to question the care provided by CBD Volunteers (Koenig et al, 2000). A third explanation may be that clients have few options and are therefore more likely to accept existing standards of care as reasonable, i.e. "any program is better than no program at all" (Koenig et al, 2000; Simmons and Elias, 1994). Finally, clients with low expectations of health services or a lack of a sense of entitlement to such services (which may be accentuated because the services are free) may be easily pleased or satisfied even if the quality of services is poor (Koenig et al, 2000; Simmons and Elias, 1994).

Efforts were made to mitigate these threats by openly acknowledging and discussing them with the research team and involved parties at the onset of the research study. Attempts were made to minimize courtesy bias by ensuring that focus group facilitators and client interviewers were not people the participants would have to rely on for family planning services in the future (Baron et al, 1993). Additionally, participants were assured of confidentiality, particularly that individual's comments would not be directly reported to CBD Volunteers. Despite these efforts, however, the role of potential biases in the selection and satisfaction of clients cannot be ruled out and are thus acknowledged as conceivable study constraints.

Small sample size

The challenges inherent in accessing clients and the subsequent need to have clients reach researchers (vs. researchers reaching clients in their own setting) attributed to the small sample size of clients available for this study. While some CBD Volunteers had never received the request to invite clients to their reporting meeting because of communication shortfalls, many expressed frustration and disappointment in not being successful in their efforts to engage more clients. CBD Volunteers reported various reasons why clients were unable to accept the invitation e.g. that women were unwilling or unable to come due to family or work obligations, that some women were shy, suspicious or fearful and that others complained of the time, distance and cost to travel to the health unit. The resulting small sample size (n=49) prevented the comparison or detection of statistical associations of variables such as client knowledge and attitude or satisfaction scores. Additionally, while it can be concluded that the clients who participated in the study were satisfied with services and willing to articulate their perspectives about the CBD program, it cannot be concluded that these results are generalizable to all clients, particularly clients using family planning covertly.

Methodology limitations

Limitations regarding the research methodology utilized to ascertain client perspectives must also be recognized. Once again, the study methodology was impacted by the inability to access clients in their own setting and the subsequent need to have clients reach the researchers. The initial intention was to augment client questionnaires with focus group discussions with clients and former or non-clients of the CBD program. Once in the field, however, it was not possible or practical to hold focus group discussions. Clients willing to be interviewed on the scheduled meeting day presented themselves at the health unit at their convenience, usually after finishing their market business. It was therefore difficult to find more than two clients present at the same

time. Most were eager to leave as quickly as possible; many had to walk long distances to reach home. The researcher and her assistants were unwilling to further inconvenience clients by asking them to wait for a focus group discussion, especially since it was not possible to confirm that other clients would show up. As a result, client perspectives could only be ascertained via questionnaires.

The sole reliance on quantitative findings i.e. client questionnaires, while not initially intended nor considered ideal by the researcher, may have resulted in misleading interpretations or data biased towards positive results. Qualitative approaches may have provided better opportunities for clients to express their feelings, or the intensity of their feelings, about the CBD program (Simmons and Elias, 1994). While Whittaker et al found quantitative surveys to be valid and useful instruments for documenting and quantifying clients' perspectives in Bangladesh (Whittaker et al, 1996), Simmons et al report that, while systematic observation of service provision has led to the finding that clients are dissatisfied with services, survey research often reveals a high level of client satisfaction (Simmons et al, 1986). Whittaker et al have also found that direct observation and post consultation interviews are better ways of assessing quality of care issues such as providers technical competence than are client interviews (Whittaker et al, 1996). Furthermore, Miller et al state that satisfaction and recommendations are "notorious areas for invalid data as clients are reluctant to criticize programs to strangers in most parts of the world" (Miller et al, 1991, p 139). A more successful combination of methodologies such as questionnaires, interviews and focus group discussions may have generated a more comprehensive picture of clients' perspectives and perceptions of the CBD program (Simmons and Elias, 1994).

9.1.2 Strengths

While the limitations of solely relying on quantitative data from client questionnaires have been acknowledged, the incorporation of opportunities for clients to define, in their own terms, their experiences with the CBD program is a notable strength. Instead of an abundance of questions that lead clients to specifically identify previously established quality criteria, various open-ended questions were included in the client questionnaire (e.g. what do you like best about the CBD program or why, if given the opportunity, would you not go elsewhere for services?). These questions encouraged spontaneity of expression and allowed subjective themes to emerge (Vera, 1993), particularly those related to quality of care e.g. "she treats me well", "I am learning more about family planning" or "I receive good advice".

Given the low morale of CBD Volunteers and the general assumption (albeit unconfirmed) that clients, primarily poor females, may be disempowered or lack a sense of entitlement with regards to family planning services, research objectives to ascertain their perspectives and the articulated conviction that their thoughts and voices would be incorporated into program goals and development may have served as a source of empowerment for participants. Vera, in her examination of client's views of family planning services in Santiago, Chile noted that the simple act of asking clients if they are satisfied is one small way to increase their feelings of empowerment (Vera, 1993). While admittedly a complex and co-optable construct (Shields, 1995), a certain sense of empowerment, entitlement or bolstered confidence was sometimes detected. Some clients, for example, demonstrated delight at being requested to sign consent forms. Following focus group discussions and questionnaires, CBD Volunteers sometimes used song and dance to express their gratitude for the opportunity to voice their opinions and concerns.

Indeed, the opportunity to hear from some of the poorest people in the world, particularly women most in need of family planning services, must be considered a privilege. This research study has allowed the thoughts and comments of clients and service providers as well as CBD Trainers, local leaders and adolescents to be recorded and incorporated into suggestions for program improvement. The selection of participants from the grassroots level, specifically poor women and adolescents whose viewpoints are not typically requested or valued, enabled the documentation of program areas requiring strengthening and the development of suggestions for improving the CBD program (Miller et al, 1991). Although not intended to serve as a comprehensive evaluation of the CBD program, this straightforward study methodology, relying on the triangulation of qualitative and quantitative data, has produced useful information regarding specific program components such as incentives, morale and supervision as well as the prevailing community challenges to family planning acceptance (Miller et al, 1991).

Perhaps the greatest strength is that the study was undertaken within an organization-development approach and that it was part of a long-term and ongoing collaboration between BHS and the researcher's supervisor, Dr. Walter Kipp. Within the organization-development tradition, research is undertaken as a way to accomplish organizational improvement and researchers work in close collaboration with members of the organization to diagnose organizational problems and identify possible interventions. By undertaking this research in concurrence with BHS staff, and at their invitation, local ownership of the research process, as well as an obligation to acknowledge findings and implement suggestions, was fostered (Simmons and Elias, 1994).

Collaboration with BHS reproductive health staff before, during and after data collection shaped the nature of the research process, including the identification of study objectives, the types of questions asked, the interpretation of study findings and nature of recommendations put forth (Simmons and Elias, 1994).

9.2 Lessons Learned

This research study, particularly the field data collection in Uganda, provided numerous opportunities for deeper understanding of the grassroots reality, and corresponding challenges, of implementing reproductive health initiatives in the developing world. Two important lessons learned are highlighted below.

First, a determinants of health approach is crucial to family planning research, whether examining the potential impact of family planning on the lives of women and children or investigating barriers to family planning access and acceptance. In this study, a determinants of health approach was instrumental in:

- attempting to ensure that the experiences clients bring to the process of family planning are taken into account (AbouZahr et al, 1996);
- facilitating an understanding of the intricate realities of the lives of both clients and service providers;
- translating the gathered perspectives of those providing and receiving CBD services into program improvements that match their needs and improve the quality of their lives (Williamson, 1998).

Furthermore, this assessment of community perspectives of CBD family planning services in Kabarole has demonstrated that a determinants of health approach is also essential when attempting to access community members and collect these perspectives. The social and cultural environment of Kabarole, the programmatic and community context in which family planning services are experienced, in combination with individual characteristics and preferences for services, while interacting to determine the quality and quantity of CBD services, also played significant roles in influencing the researcher's ability to gain access to community members, particularly clients, in the first place. A determinants of health approach, therefore, while essential during data analysis and the formulation of recommendations for improvement, must also be incorporated into the initial study design. Additionally, it is fundamental to a deeper appreciation of study design strengths and limitations and their implications for future research

initiatives and approaches. Indeed, it must be recognized that the logistical difficulties (i.e. geography, travel distances, cost, security, inclement weather, road conditions etc.) and socio-cultural factors (i.e. community disapproval, secrecy and confidentiality issues) that made access to clients so challenging are the very features determining client's needs for CBD services in the first place.

A second and associated lesson is that the socioeconomic context in which family planning services are received and provided must not only be acknowledged but also directly addressed by program initiatives aimed at improving reproductive health. In Kabarole, female clients' abilities to manage their reproductive health issues or negotiate contraceptive use are directly related to their socioeconomic status and power. Likewise, CBD Volunteers' poor socioeconomic standing and subsequent preoccupation with their own empty stomachs impact the quantity and quality of CBD services offered. Building a client orientation or bringing quality of care issues to the fore assume secondary significance to the paramount need to consider provider's basic requirements and humble requests. Despite the volunteer status of CBD service providers and CBD program resource constraints, Basic Health Services must acknowledge its professional and moral obligation to cover the basic and minimal transport and food needs of CBD Volunteers during monthly meetings. CBD Trainers and BHS staff often expressed both personal and professional frustration over the fact that CBD Volunteers sometimes spend the whole day, without even a small lunch, at the health unit for their monthly meetings. A staff member once commented that it was disturbing for her *"to see these poor women walking the long distances back home empty-handed, and with empty stomachs."* Additionally, support for the income generating or micro-credit activities, in the form of training, facilitation and local capacity building, can be instrumental in enhancing the financial self-sufficiency of CBD Volunteers.

This lesson, though acquired in Kabarole, has macro level applicability as well. Reproductive health initiatives in the developing world must recognize that the low social and economic status of women and girls sets the stage for poor reproductive health and that investing in women's health, education and economic opportunities is critical to lowering reproductive risk (Population Action International, 2001). Program implications are inherent in such an acknowledgement: it means that reproductive health initiatives must be viewed from within the broader framework of sustainable community development: it requires that community members, women in particular, are given more life choices and that their unequal access to resources is articulated; it highlights

the need to forge partnerships within institutions and across sectors and finally, it demands the involvement of communities (Population Action International, 2001).

Only after listening to the goals and aspirations of both those providing and receiving reproductive services can effective and accepted programs be designed to match their priorities and improve the quality of their lives.

9.3 Future Research Directions

The budgetary and personnel constraints experienced in Kabarole, similar to those found in many developing country settings, make extensive wish lists for future research impractical. However, the enthusiasm and interest expressed by graduate students and their supervisors in Uganda, as well as in Canada, to explore issues in Kabarole warrants this consideration of three possible future research directions.

First, since rumours and misconceptions about contraceptive methods, as well as fears of the consequences of their use, appear to dramatically increase the social costs of family planning adoption in Kabarole, further investigation into these misconceptions may facilitate the development of effective information, communication and education strategies to demystify contraceptives and depict responsible reproductive decision-making in a more culturally-appelling manner. Research into the fears and sensitivities people have about birth spacing and birth limiting is perhaps most effective when it is multidisciplinary, incorporating perspectives from public, population and reproductive health, communication and education as well as a keen appreciation of national, regional and local cultures.

Male involvement in family planning also merits future research consideration. Is male approval of family planning on the rise in Kabarole as it appears to be in other regions of sub-Saharan Africa? Why are men in Kabarole reluctant to use services? What is the extent of their information and misinformation about their own and women's reproductive lives? Are they the believers and propagators of rumours and myths and if so, what socio-cultural or power dynamics make this a beneficial endeavour? Since evidence from the developing world suggests that many more men would participate in family planning if given the opportunity to do so, what, according to males in Kabarole, can be done to encourage male involvement? Ideally, research should translate directly into effective program strategies to increase communication between partners (and ultimately with their children, particularly boy children), encourage men to support women's

contraceptive choices, increase use of male methods, improve men's behaviour towards STD prevention and address men's own reproductive needs. Incorporated in an examination of male involvement is the need for project managers and service providers to overcome their own assumptions or generalizations about men (e.g. men are disinterested in family planning, men disapprove) as well as their own personal and cultural biases towards men and women. "Understanding personal opinions about gender-related issues is a fundamental step toward better service provision" (Ndong and Finger, 1998, p 6).

Finally, in light of adolescents' misinformation and lack of access to youth-friendly reproductive health services, further investigation is needed into the barriers to adolescent's effective access to sexual and reproductive health information, contraceptive methods and means of STD prevention. The identification of specific strategies for improving both the quality and quantity of service provision available to adolescents should be considered a fundamental element of this examination. Though often considered logistically complex, the views and experiences of out-of-school adolescents should be incorporated alongside those of in-school adolescents. Research pertaining to adolescent reproductive health issues should strive to take into account the economic and socio-cultural constraints faced by adolescents in Kabarole and consider the role of gender norms in adolescent's decision making about sexual and reproductive behaviours.

9.4 Conclusion

Increased family planning access and acceptance, thanks largely to the CBD Volunteer program and CBD Volunteer efforts, is contributing to positive changes in Kabarole, western Uganda. However, a web of complex and interacting community challenges and program related problems combine to constrain potential CBD program impact and sustainability. While accessibility is important for the geographically and economically marginalized populations of Kabarole, the social acceptability of family planning use appears paramount. Clearly, attempts to enhance family planning utilization in Kabarole must go beyond the simple provision of accessible supplies to include the programmatic, cultural and psychosocial dimensions that affect client's use of services and CBD Volunteers' provision of services.

CBD Volunteers appear ideally placed to meet the challenges of increasing both the accessibility and acceptability of family planning. While providing a convenient supply of contraceptives they can be instrumental in reducing fear and misconceptions about contraceptive use, encouraging

male participation, addressing religious and cultural barriers to family planning and mobilizing overall community support.

It can be concluded from the data that CBD Volunteers have the knowledge necessary to provide reasonably good care to family planning clients. It remains less clear, however, if they have the motivation or inclination to provide quality care (Miller et al, 1991). The first approach to ensuring the sustainability and success of the CBD program appears to be in tackling the issues of CBD motivation and morale. The immediate selection and implementation of sustainable schemes to motivate Volunteers – schemes that are within the local financial capacity and based on CBD Volunteers' preferences – are the most crucial and compelling issues for Basic Health Services at this time.

Finally, the conditions and social factors that led to the birth of the CBD program in the first place have not ceased to exist in Kabarole. CBD of family planning has a crucial role to play. CBD Volunteers, if motivated and supported, can provide individuals with information to meet their reproductive health needs and services that allow them to decide freely and responsibly the number and spacing of their children.

REFERENCES

- AbouZahr C, Vlassoff C, Kumar A. Quality health care for women: a global challenge. *Health Care for Women International* 1996; 17: 449-467.
- Agyei WK, Migadde M. Demographic and sociocultural factors influencing contraceptive use in Uganda. *Journal of Biosocial Science* 1995; 27: 47-60.
- Baden S, Wach H. *Gender, HIV/AIDS Transmission and Impacts: A Review of Issues and Evidence*. Briefings on Development and Gender Report No 47. Brighton, UK: Institute of Development Studies; 1998.
- Baguma C. *Cultural practices which influence girl child education and marriage in Kabarole district*. Unpublished report. Kabarole: Tooro Kingdom Population and Development Project; 2000.
- Bajenja E, Mboijana C, Nyinakamunyu J, Muyinda H. *Knowledge, attitude and practice study on contraception in selected areas in Kabarole district*. Unpublished report. Kabarole: Basic Health Services; 1998.
- Barnett B. What is a "gender sensitive" program? *Network* (Family Health International) 1999; 18 (4).
- Barnett B. Gender norms affect community distribution. *Network* (Family Health International) 1999; 19 (3).
- Baron D, Kumah OM, Lettenmaier C, Krenn S, Bashin M, Jato M, Church C, Kim YM, Langlois P. *Qualitative Research for Family Planning in Africa*. Maryland: Centre for Communication Programs, Johns Hopkins School of Public Health; 1993.
- Baryomunsi C. *Improving access to family planning services in rural areas of Uganda: The GTZ supported CBD programme in Kabarole district, western Uganda*. Presentation: Kampala: Uganda Medical Association Annual Scientific Conference; October 19-20 2000.
- Bauni EK, Obonyo Jarabi B. Family planning and sexual behaviour in the era of HIV/AIDS: the case of Nakuru district, Kenya. *Studies in Family Planning* 2000; 31(1): 69-80.
- Bertrand JT, Hardee K, Magnani RJ, Angle MA. Access, quality of care and medical barriers in family planning programs. *International Family Planning Perspectives* 1995; 21 (2): 64-69 & 74.
- Bertrand JT, McBride AM, Mangani N, Baughman NC, Kinuani M. Community-based distribution of contraceptives in Zaire. *International Family Planning Perspectives* 1993; 19 (3): 84-91.
- Bertrand JT, Brown JE, Ward VM. Techniques for analyzing focus group data. *Evaluation Review* 1992; 16 (2): 198-209.
- Bertrand J, Guerra de Salazar S, Mazariegos L, Salanic V, Rice J, Kolars Sow C. Promoting birth spacing among the Maya-Quiche of Guatemala." *International Family Planning Perspectives* 1999; 25 (4): 160-167.

Best K. Contraception influences quality of life: health and relationships with others are among ways family planning use relates to quality of life. *Network* (Family Health International) 1998; 18 (4). [http:// www.fhi.org](http://www.fhi.org).

Best K. Community-based distribution serves unmet need. *Network* (Family Health International) 1999; 19(3).

Blanc AK, Wolff B, Gage AJ, Ezeh AC, Neema S, Ssekamatte-Ssebuliba J. *Negotiating reproductive health outcomes in Uganda*. Calverton, Maryland: Macro International Inc. and Institute of Statistics and Applied Economics, Uganda; 1996.

Bouzidi M, Fischer C (Eds). *Community-based family planning services in Africa: The program manager's perspective*. Harare: GTZ and International Planned Parenthood (IPPF); 1991.

Bruce J. Fundamental elements of the quality of care: a simple framework. *Studies in Family Planning* 1990; 21 (2): 61-91.

Caldwell A, Barkat-e-Khuda. The first generation to control family size: a microstudy of the causes of fertility decline in a rural area of Bangladesh. *Studies in Family Planning* 2000; 31 (3): 239-251.

Center for International Health Information (CIHI). *Health and demographic overview - CIHI health statistics report: Uganda*. Arlington VA USA: Center for International Health Information; 1999.

Cleland J. Family planning programmes for the next century. *ID21 Insights* 1997; 22.

Collymore Y. Uganda beats back HIV/AIDS. *Population Today*. Washington: Population Reference Bureau; 1999.

District Health Management Team (DHMT). *Kabarole District Population Data/Fact Sheet*. Kabarole: Kabarole district medical service statistics; 2000.

District Health Management Team (DHMT). *Indicators for monitoring Kabarole district health services performance*. Kabarole: Kabarole District medical service statistics; 2000.

Durbin S. Spotlight on Uganda. *Population Today*. Washington: Population Reference Bureau; 1997, p 8.

Edwards N. Editorial - Population health: determinants and interventions. *Canadian Journal of Public Health* 1999; 90 (1): 10-11.

Evans I, Huezo C. (Eds.) *Family planning handbook for health professionals: The sexual and reproductive health approach*. London: International Planned Parenthood Federation; 1997.

Family Health International (FHI). *Frequently asked questions on contraception*. Retrieved from the FHI homepage; 2001. [http:// www.fhi.org](http://www.fhi.org)

Ferguson A. *Community-based reproductive health strategy and workplan, Kabarole District*. Consultancy Report prepared for GTZ Basic Health Services Project, Western Uganda; July 1998, p 1-33.

- Finger WR. Four CBD programs. *Network* (Family Health International) 1999; 19 (3).
- Finger WR. Offering CBD and other Services. *Network* 1999; 19 (3).
- Finger WR. Motivating community-based workers. *Network* 1999; 19 (3).
- Finlay H, Fitzpatrick M, Fletcher M, Ray N. Uganda. *Lonely Planet East Africa* (5th edition). Victoria, Australia: Lonely Planet Publications Pty Ltd; 2000.
- Foreit JR, Foreit KG. Quarterly versus monthly supervision of CBD family planning programs: an experimental study in northeast Brazil. *Studies in Family Planning* 1984; 15 (3): 112-120.
- Friedman HL. Reproductive health in adolescence. *World Health Statistics Quarterly* 1994; 47: 31-35.
- Gammeltoft T. *Women's bodies, women's worries: Health and family planning in a Vietnamese rural community*. Nordic Institute of Asian Studies: Curzon; 1999.
- Grimes BF, Editor. *Ethnologue* (13th edition). Summer Institute of Linguistics, 1996.
- Hatcher RA, Rinehart W, Blackburn R, Geller JS. *The essentials of contraceptive technology: A handbook for clinic staff*. Baltimore: Johns Hopkins School of Public Health, Population Information Program; 1997.
- Health Canada Conceptual Framework Subgroup on Population Health. *Towards a Common Understanding: Clarifying the Core Concepts of Population Health, A Discussion Paper*. Ottawa: Health Canada; 1996.
- Hong S, Seltzer J. *The impact of family planning on women's lives: a conceptual framework*. Family Health International Working Paper 94-02; 1998. <http://www.fhi.org>
- Hulton LA, Cullen R, Khalokho SW. Perceptions of the risks of sexual activity and their consequences among Ugandan adolescents. *Studies in Family Planning* 2000; 31(1): 35-46.
- International Family Health (IFH). 2001. Retrieved from homepage <http://www.oneworld.org/ifh>
- Jain A, Bruce J, Mensch B. Setting standards of quality in family planning programs. *Studies in Family Planning* 1992; 23 (6): 392 – 395.
- Kabwa PB. Family planning is about health and life, not numbers! *The New Vision* 15, (255). Kampala: The New Vision; October 24, 2000.
- Kaida A. *Knowledge, Attitudes, and Practice of Married Men Toward Family Planning in Mpigi District, Central Uganda*. Edmonton: University of Alberta; 2001.
- Kaler A. *Family planning in western Kenya: Why providers don't follow the rules*. Presentation: Edmonton: Interdisciplinary International Health Rounds, University of Alberta; April 9, 2001.
- Katz KR, West CG, Doumbia F, Kane F. Increasing access to family planning services in rural Mali through community-based distribution. *International Family Planning Perspectives* 1998; 24 (3): 104-110.

- Kilian A, Ndyabangi B, Kabagambe G and Rubaale T (Eds). *Improving Health in the Districts of Kabarole and Bundibugyo: The Past, Present and Future*. Unpublished report. Kabarole: Basic Health Services; August 1997.
- Kim YM, Kols I, Mwarogo P, Awasum D. Difference in counselling men and women: family planning in Kenya. *Patient Education and Counselling* 2000; 39 (1): 37-47.
- Kipp W. Personal communication; April 20, 2001.
- Kitts J, Hatcher Roberts J. *The health gap: Beyond pregnancy and reproduction*. Ottawa: International Development Research Centre; 1996.
- Koenig M, Foo G, Joshi K. Quality of care within the Indian family planning welfare programme: a review of recent evidence. *Studies in Family Planning* 2000; 31(1): 1-18.
- Koenig MA and Khan ME. (Eds). *Improving Quality of care in India's Family Welfare Programme: The Challenge Ahead*. New York: The Population Council, 1999.
- Lutalo T, Kidugavu M, Wawer MJ, Serwadda D, Zabin LS, Gray RH. Trends and determinants of contraceptive use in Rakai district, Uganda, 1995-98. *Studies in Family Planning* 2000; 31 (3): 217-227.
- Mayhew SH, Lush L, Cleland J, Walt G. Implementing the integration of component services for reproductive health. *Studies in Family Planning* 2000; 31 (2):151-162.
- Miller RA, Ndhlovu L, Gachara MM, Fisher AA. The Situation Analysis Study of the Family Planning Program in Kenya. *Studies in Family Planning* 1991; 22 (3): 131-143.
- Ministry of Health (MOH). *National health policy*. Kampala: Ministry of Health, Republic of Uganda; 1999.
- Morse J, Field PA. *Qualitative Research Methods for Health Professionals*. Thousand Oaks, California: SAGE Publications; 1995.
- Ndong I, Finger WR. Male responsibility for reproductive health. *Network* (Family Health International) 1998; 18 (3): 4-6.
- Neuman WL. *Social research methods: Qualitative and quantitative approaches* (4th edition). Boston: Allyn and Bacon; 2000.
- Newton N. "Applying best practices to youth reproductive health". *Lessons Learned from Family Planning and Service Expansion and Technical Support (SEATS) Quality of Care Initiative*; January 2000. www.seats.jsi.com
- Nuwaha F, Faxelid E, Neema S, Hojer B Lay people's perceptions of sexually transmitted infections in Uganda. *International Journal of STD & AIDS* 1999 November; 10 (11):709-17.
- Osborn RW, Reinke WA (Editors) *Community based distribution of contraception: A review of field experience*. Baltimore: Johns Hopkins Population Centre, The Johns Hopkins University, School of Hygiene and Public Health; 1981.

- Paulson S. Opinion: gender insights can improve services. *Network* (Family Health International) 1998; 18 (4).
- Phillips JF, Hossain MB, Arends-Kuenning M. The long-term demographic role of community-based family planning in rural Bangladesh. *Studies in Family Planning* 1996; 27 (4): 204-19.
- Phillips J, Greene W, Jackson E. *Lessons from Community-based Distribution of Family Planning in Africa*. Policy research Division Working Paper No. 121. New York: The Population Council; 1999.
- Planned Parenthood Federation of America (PPFA). International family planning makes a world of difference – for women, their families, their communities, and the earth. *Fact Sheet*. New York: Katharine Dexter McCormick Library, Planned Parenthood Federation of America; 1999.
- Population Action International (PAI). “A world of difference: Sexual and reproductive health and risks.” *Population Action International Report Card*; 2001. Retrieved from [http:// www.populationaction.org/worldofdifference/rr2_strategies.htm](http://www.populationaction.org/worldofdifference/rr2_strategies.htm).
- Population Council. *Community-Based Distribution Programme Briefs*. Africa Operations Research and Technical Assistance Project II. New York: The Population Council; 1998, p. 1-12.
- Population Information Network (POPIN). Uganda Country Profile. *Country Profiles 1998*. Geneva: United Nations Population Information Network; 1998. [http:// www.ippf.org](http://www.ippf.org)
- Population Reference Bureau (PRB). *World Population Datasheet – Africa*. Washington, DC: Population Reference Bureau; 1999. [http:// www. prb. org](http://www.prb.org)
- Reutter L, Neufeld A, Harrison MJ. Using critical feminist principles to analyze programs for low-income urban women. *Public Health Nursing* 1995; 12 (6): 424-431.
- Reproductive Health Outlook (RHO): an on-line reproductive health library produced by Program for Appropriate Technology in Health (PATH); 2000. [http:// www.rho.org](http://www.rho.org)
- Richman JA, Jason LA, Taylor RR and Jahn SC. Feminist perspectives on the social construction of Chronic Fatigue Syndrome. *Health Care for Women International* 2000; 21: 173-185.
- Robey B, Drennan M. Male participation in reproductive health. *Network* (Family Health International) 1998; 18 (3): 11-15.
- Rothe JP. *Qualitative research: A how-to manual for keeners*. Heidelberg ON: RCI Publications; 1994.
- Rothe JP. *Injury and Qualitative Research: A Practical Guide*. Edmonton, Alberta: University of Alberta Press; 1994.
- Rutakumwa W. *Quality of health care for Ugandan rural women*. Edmonton: University of Alberta; 2000.
- Schuler SR, Hossain Z. Family planning clinics through women’s eyes and voices: a case study from rural Bangladesh. *International Family Planning Perspectives* 1998; 24 (4): 170-175 & 205.

Sebunya C. Words not weapons needed in Uganda. *New Internationalist (NI) Magazine*. Adelaide, Australia: New Internationalist Publications Ltd.; 1998, October 306, p 5.

Shelton JD, Bradshaw L, Hussein B, Zubair Z, Drexler T, Reade McKenna M. Putting unmet need to the test: community based distribution of family planning in Pakistan. *International Family Planning Perspectives* 1999; 25 (4): 191-195.

Shields LE. Women's experiences with the meaning of empowerment. *Qualitative Health Research* 1995; 5 (1): 15-35.

Simmons R, Elias C. The study of client-provider interactions: a review of methodological issues. *Studies in Family Planning* 1994; 25 (1): 1-17.

Simmons R, Baqee L, Koenig M, Phillips J. Beyond supply: the importance of female family planning workers in rural Bangladesh. *Studies in Family Planning* 1988; 19 (1) 29-38.

Simmons R, Koblinsky MA, Phillips JF. Client relations in South Asia: programmatic and societal determinants. *Studies in Family Planning* 1986; 17 (6): 257-266.

Uganda Country Profile. *New Internationalist (NI) Magazine*. Adelaide, Australia: New Internationalist Publications Ltd. 1995; 272, p 36.

Simply – Sudan/Uganda. *New Internationalist (NI) Magazine*. Adelaide, Australia: New Internationalist Publications Ltd. 1996; 283, p 26.

Smith PG and Morrow RH. *Field Trials of Health Interventions in Developing Countries: A Toolbox*. London and Basingstoke: Macmillan Education; 1996.

Speizer IS, Hotchkiss DR, Magnani RJ, Hubbard B, Nelson K. Do service providers in Tanzania unnecessarily restrict clients' access to contraceptive methods? *International Family Planning Perspectives* 2000; 26 (1): 13-20 & 42.

Uganda youth top regional fertility. *The New Vision* 15 (246). Kampala: The New Vision; October 16, 2000.

United Nations AIDS / World Health Organization Working Group on Global HIV/AIDS and STI Surveillance. *Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections. Uganda 2000 Update*. Geneva: United Nations AIDS and World Health Organization; 2000.

Update: debt relief. *New Internationalist (NI) Magazine*. Adelaide, Australia: New Internationalist Publications Ltd. September 1997; 294, p 5.

United States Agency for International Development. Taita Taveta health and population project. *Lessons Without Borders*. Washington: United States Agency for International Development (USAID); 1999.

Vera H. The client's view of high-quality care in Santiago, Chile. *Studies in family Planning* 1993; 24 (1): 40-49.

Waisa G, Kabagamba RG. *Adherence of health workers to NTLP guidelines in the management of tuberculosis in three hospitals in Kabarole district*. Unpublished report. Fort Portal: District Health Management Team; August 2000.

Wawer M, Huffman S, Cebula D, Osborn R. *Health and Family Planning in Community Based Distribution Programs*. Boulder, Colorado: Westview Press, 1985.

Whittaker M, Mita R, Hossain B, Koenig M. Evaluating rural Bangladeshi women's perspectives of quality in family planning services. *Health Care for Women International* 1996; 17: 393-411.

Werner D. Elusive Promise. *New Internationalist (NI) Magazine*. Adelaide, Australia: New Internationalist Publications Ltd. (331); Jan/Feb 2001, p 22-23.

Westoff CF, Bankole A. Trends in the demand for family limitation in developing countries". *International Family Planning Perspectives* 2000, 26 (2): 56-62 & 97.

Williams T, Schutt-Aine J, Cuca Y. Measuring family planning service quality through client satisfaction interviews. *International Family Planning Perspectives* 2000; 26 (2): 56-62 & 97.

Williamson N. Introduction: how family planning use affects women's lives. *Network* (Family Health International) 1998; 18 (4). <http://www.fhi.org>

Wolff B, Blanc AK, Ssekamatte-Ssebuliba J. The role of couple negotiation in unmet need for contraception and the decision to stop childbearing in Uganda. *Studies in Family Planning* 2000; 31 (2): 124-137.

World Bank Group. Uganda Country Brief. *A World Free of Poverty*; 2000.
<http://www.worldbank.org/afr/ug>

World Health Organization (WHO). *Community-Based Distribution of Contraceptives: A Guide for Program Managers*. Geneva: World Health Organization; 1995.

World Health Organization (WHO). *Communicating family planning in reproductive health: key messages for communicators*. Geneva: World Health Organization, Family Planning and Population; 1997.

Appendix 1:
Map of Africa



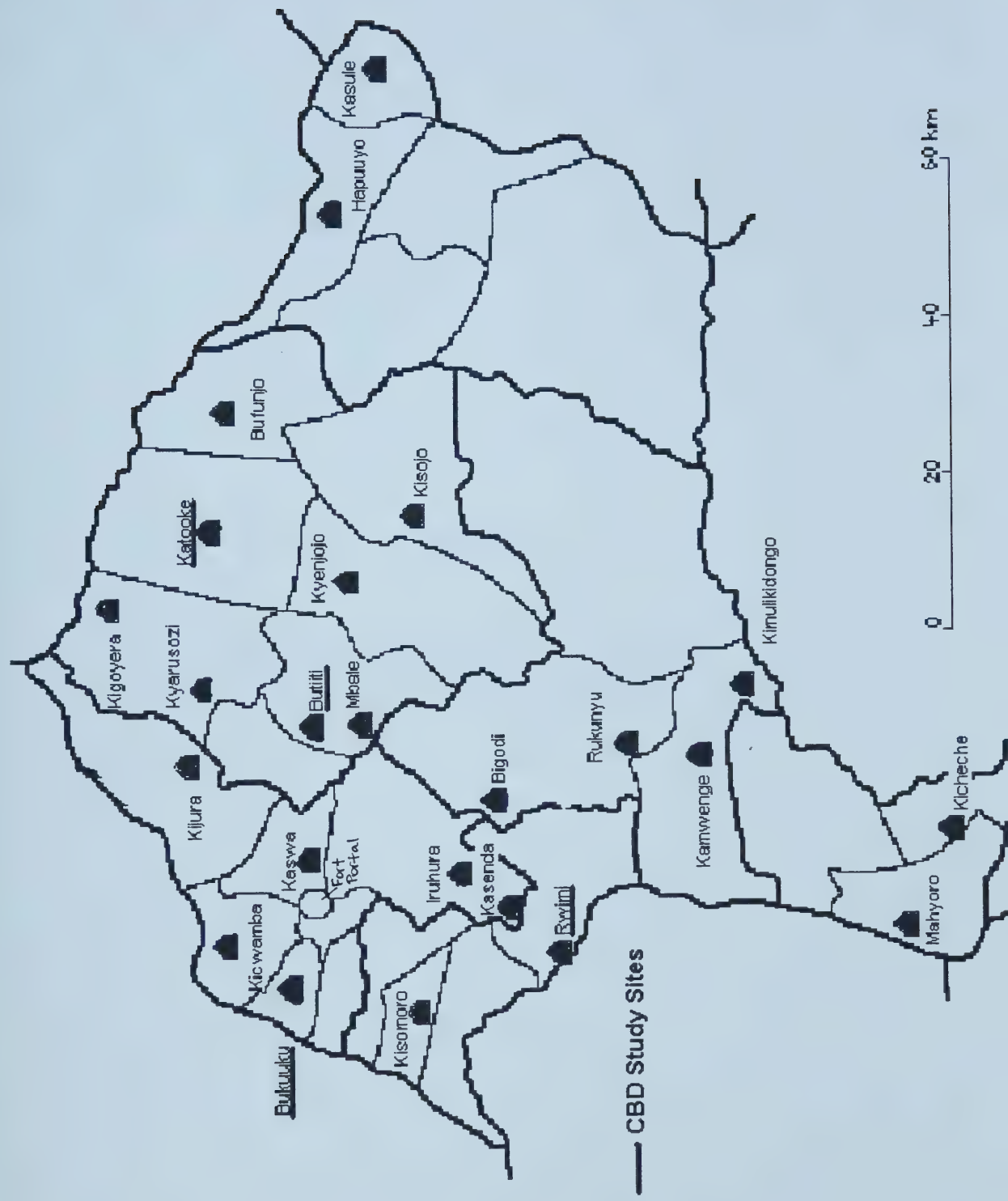
Appendix 2:
Map of Uganda



Appendix 3:

Map of CBD Sites in Kabarole District, Western Uganda (Four Study Sites are underlined)

CBD SITES IN KABAROLE DISTRICT



Appendix 4:

Information Letters for Study Participants (including questionnaire respondents and focus group discussion participants)

Information Letter (for questionnaire respondents)

Project Title:	Community-based distribution of family planning: perspectives from Kabarole, Uganda.	
Investigators:		
Dr. Chris Baryomunsi	Basic Health Services Fort Portal, Kabarole district, Uganda	258-483-22575
Mr. Tom Rubaale	Basic Health Services Fort Portal, Kabarole district, Uganda	258-483-22575
Ms. Annette Flaherty	Department of Public Health Sciences University of Alberta Edmonton, Alberta, Canada	258-483-22575

October 1, 2000

Dear Participant:

You are being asked to participate in a study that is looking at what community members think of the family planning community program that is available in your area. This study is being done by Basic Health Services (BHS) in Fort Portal and a student from the University of Alberta in Alberta, Canada.

Purpose of the Study

The reason for this study is to have a better understanding of people's experiences with the community family planning program. We would like to know why people use the program and why they do not use the program. This information will help us to make changes so that we have a better program in the future.

The information is also being collected as part of a graduate student's thesis project.

Background

Family planning includes the various ways or methods that people use to delay or avoid a pregnancy. BHS began a program so that people can get family planning without having to visit a hospital or health centre. In this program, people from the community receive special training on family planning. After training, they visit people who are interested in receiving good information about family planning and safe and simple ways not to become pregnant.

BHS would like to know what you like or do not like about this program. We would like to get your ideas on how the program can be **changed** to make it better. A better program will mean better family planning services for people in Kabarole.

We will be meeting with about 50 of the volunteer family planning workers. We will also talk to about 50 people who are now using the program.

Procedures

A trained interviewer will ask you questions from a questionnaire. The questions will be about your experiences with the community based distribution program for family planning, what you know about family planning in the district and what you would like to see done differently. Unless you would like to communicate in English, the questions will be asked in Rutoroo. Your answers will be recorded. Answering the questionnaire will take about 45 minutes. Meetings will take place at the health center.

Possible benefits

At the end of the questionnaire, the interviewer will ask you if you have any questions about the study or about the program offered by BHS. If she cannot answer your questions, she will refer you to someone else. This person will be able to answer your questions.

The information from this study will help BHS to make changes to the community family planning program. These changes will help people who are providing the services. They will also help people who are receiving family planning. Better family planning will mean better health for women, children and whole families in Kabarole.

Possible harms

There are no expected risks or harms to taking part in this study. We do not want you to feel any stress or pressure about sharing information with us. If you feel badly while you are participating, please remember that you can leave at any time. If you feel badly after you have shared information with us, please tell us. You can also talk to a worker at the Fort Portal Health Information Centre located in Fort Portal. If you want, the researchers can make arrangements for you to receive help from the health workers at the Health Information Centre or at BHS.

Confidentiality and voluntary participation

All records will be kept private. All your answers will be nameless. These papers, the questionnaires and information from group discussions will be kept in a secure area. Only the researcher, her supervisor at her University in Canada and the research assistant will have access to the information you give.

We will report to BHS about what we learn from this study. However, we will not tell them specifically what you said or did. We will not tell them what any individual person has said. Instead, we will tell them about the comments of the whole group of people together. We will never use your name. Nobody will be able to trace your responses back to you.

The information collected in this study will be kept for at least five years after the study is finished. It will be kept in a secure place at the University of Alberta in Canada. Only the research team will have access to this stored information. If we plan to use this information for more studies, we will get further ethics approval first.

You are not required to participate in this study. You do not have to participate if you do not want to. You do not have to answer any questions that you do not want to. You can also leave the study anytime you want to, without fear that anything bad will happen.

For more information on the study

If you have any concerns about this study or would like more information, please contact Annette Flaherty or Dr. Chris Baryomunsi at the Basic Health Services office in Fort Portal. The phone number at BHS is 258-483-22575. You may also contact the District Medical Officer for Fort Portal (Ministry of Health), Dr. Geoffrey Kabagambe, at 258 483 22743.

Your consent and legal rights

Your signature on the next page means that you understand the information in this letter. It also means that you agree to participate in this study.

Please keep these pages in case you need them in the future.

Information Letter (for focus group discussion participants)

Project Title:	Community-based distribution of family planning: perspectives from Kabarole, Uganda.	
Investigators:		
Dr. Chris Baryomunsi	Basic Health Services Fort Portal, Kabarole district, Uganda	258-483-22575
Mr. Tom Rubaale	Basic Health Services Fort Portal, Kabarole district, Uganda	258-483-22575
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The information is also being collected as part of a graduate student's thesis project.

Background

Family planning includes the various ways or methods that people use to delay or avoid a pregnancy. BHS began a program so that people can get family planning without having to visit a hospital or health centre. In this program, people from the community receive special training on family planning. After training, they visit people who are interested in receiving good information about family planning and safe and simple ways not to become pregnant.

BHS would like to know what you like or do not like about this program. We would like to get your ideas on how the program can be changed to make it better. A better program will mean better family planning services for people in Kabarole.

We will be meeting with about 50 of the volunteer family planning workers. We will also talk to about 50 people who are now using the program.

Procedures

You are invited to attend a meeting for a group discussion. There will be between six and eight people in this group discussion. The discussion will take place in Rutoroo unless the group would like to communicate in English. The discussion will take about one and a half hours. A trained interviewer will ask a few questions. The questions will be about the community family planning program, what you think of it and what you think could be done differently. The interviewer will encourage you and the other people to share your experiences and ideas. It will also be a time to get more ideas on how to make the program better. The interviewer will ask you if he/she can tape the discussion. The words from the tapes will be put onto paper. These words will be studied in detail later by the investigators.

Possible benefits

At the end of the discussion, the interviewer will ask you if you have any questions about the study or about the program offered by BHS. If she cannot answer your questions, she will refer you to someone else. This person will be able to answer your questions.

The information from this study will help BHS to make changes to the community family planning program. These changes will help people who are providing the services. They will also help people who are receiving family planning. Better family planning will mean better health for women, children and whole families in Kabarole.

Possible harms

There are no expected risks or harms to taking part in this study. We do not want you to feel any stress or pressure about sharing information with us. If you feel badly while you are participating, please remember that you can leave at any time. If you feel badly after you have shared information with us, please tell us. You can also talk to a worker at the Fort Portal Health Information Centre located in Fort Portal. If you want, the researchers can make arrangements for you to receive help from the health workers at the Health Information Centre or at BHS.

Confidentiality and voluntary participation

All records will be kept private. All your answers will be nameless. These papers, the questionnaires and information from group discussions will be kept in a secure area. Only the researcher, her supervisor at her University in Canada and the research assistant will have access to the information you give.

We will report to BHS about what we learn from this study. However, we will not tell them specifically what you said or did. We will not tell them what any individual person has said. Instead, we will tell them about the comments of the whole group of people together. We will never use your name. Nobody will be able to trace your responses back to you.

The information collected in this study will be kept for at least five years after the study is finished. It will be kept in a secure place at the University of Alberta in Canada. Only the research team will have access to this stored information. If we plan to use this information for more studies, we will get further ethics approval first.

You are not required to participate in this study. You do not have to participate if you do not want to. You do not have to answer any questions that you do not want to. You can also leave the study anytime you want to, without fear that anything bad will happen.

For more information on the study

If you have any concerns about this study or would like more information, please contact Annette Flaherty or Dr. Chris Baryomunsi at the Basic Health Services office in Fort Portal. The phone number at BHS is 258-483-22575. You may also contact the District Medical Officer for Fort Portal (Ministry of Health), Dr. Geoffrey Kabagambe, at 258 483 22743.

Your consent and legal rights

Your signature on the next page means that you understand the information in this letter. It also means that you agree to participate in this study.

Please keep these pages in case you need them in the future.

Appendix 5

Consent Form for Study Participants

Title of Project: Community based distribution of family planning:
Perspectives from Kabarole, Uganda.

Principle Investigator:
Ms. Annette Flaherty Department of Public Health Sciences 258-483-22575
University of Alberta, Edmonton, Canada

Co-Investigators in Uganda:
Dr. Chris Baryomunsi Basic Health Services 258-483-22575
Fort Portal, Kabarole, Uganda

Mr. Tom Rubaale Basic Health Services 258-483-22575
Fort Portal, Kabarole, Uganda

Do you understand that you have been asked to be in a research study? Yes No

Have you read and received a copy of the attached Information Letter? Yes No

Do you understand the benefits and risks involved in taking part in this research study? Yes No

Have you had an opportunity to ask questions and discuss this study? Yes No

Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason. This will not affect your future health or family planning services that are available to you. Yes No

Has the issue of confidentiality been explained to you? Do you understand who will have access to your records? Yes No

This study was explained to me by: _____

I agree to take part in this study.

_____ Signature of Research Participant	_____ Date	_____ Witness
_____ Printed Name		_____ Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ Signature of the Investigator or Designee	_____ Date
--	---------------

Appendix 6

Letter to Secondary School Head Master

Basic Health Services
Kabarole & Bundibugyo Districts
Ministry of Health and German Development Cooperation
P.O. Box 27, Fort Portal, Western Uganda, Tel: 00256 483 22575

October 13, 2000

Attention to: Head Master, Maddox Secondary School, Butiiti

Dear Sir:

The Basic Health Services Project in Fort Portal is presently carrying out a study entitled "Community-based distribution (CBD) of family planning in Kabarole: assessing community perceptions and experiences." This research is being done in conjunction with Annette Flaherty, a Public Health Graduate student from the University of Alberta in Canada. Ms. Flaherty, together with research assistants, has been administering questionnaires to CBD volunteers and clients in various sub-counties in Kabarole district.

At this time, we are also very interested in learning about the experiences of adolescents. We would be grateful for the opportunity to hold group discussions with students at your school. The discussions are intended to gather adolescents' experiences and ideas about community based family planning services. We are interested in gathering young people's suggestions on how the community-based family planning program can be improved to better meet the specific information and service needs of young people.

We are scheduled to be in Butiiti on **Thursday, November 2nd**. If convenient, we would appreciate the opportunity to visit your school to conduct group discussions on this day between the hours of 2:00 and 4:00 pm.

We are proposing two separate group discussions, one with male students and one with female students. The students should be at S1 level or between the ages of 14 –17 years. Only 8-10 female and 8-10 male students are required and each group discussion would be 45-60 minutes maximum. Students should participate on a purely voluntary basis. It is not necessary for participants to have prior knowledge or experience with CBD services or family planning. Upon arrival, we will make a draw to ensure a random selection of interested participants.

We hope that the above arrangements will meet your convenience and satisfaction. Please confirm your agreement as soon as possible by sending a response to us via Beatrice Monday, the CBD trainer at the Butiiti Health Unit, or by contacting us directly at the Basic Health Services Office in Fort Portal.

We look forward to a favorable response from you at your earliest convenience.

Thank you in advance,

Dr. Chris Baryomunsi
Reproductive Health Consultant
Basic Health Services, Fort Portal

Annette Flaherty
Public Health Graduate Student
University of Alberta, Canada

Appendix 7

CBD Volunteer Questionnaire

Interviewer, before beginning the questionnaire, please:

- Confirm that the respondent is presently active as a CBD,
- Review the consent form with the respondent and request a signature,
- Tell the respondent that most questions simply require them to answer yes or no or to select one answer. There are also some open questions that ask for their suggestions and opinions.

County: _____	Sub-County: _____
Questionnaire number: _____	Date: _____
Sex of respondent: Male _____	Female _____
Name of Interviewer: _____	

1. How old are you? _____ (years)
2. What is your ethnic group (tribe)?
 ___ Mutooro ___ Mukiga ___ Other (please specify) _____
3. What is your religion?
 ___ Catholic ___ Protestant (Anglican/Church of Uganda)
 ___ Muslim ___ Other (please specify) _____
4. What is the highest level of school you attended?
 ___ None ___ Primary ___ Lower Secondary (S1-4)
 ___ Upper secondary (S5-6) ___ Post-secondary (University/Vocational College)
5. Does your household have a radio? ___ Yes ___ No
6. What is your job? (*ask about the job of the respondent only, not spouse*)
 ___ Farming/peasant/cultivating ___ Animal husbandry
 ___ Business/service/selling ___ Other, please specify _____
7. a) What is your marital status?
 ___ Single ___ Married ___ Divorced / Separated ___ Widowed
 b) If married, in polygamy or monogamy? _____
8. How many pregnancies have you had in your life in total? _____
 (*For men, ask how many children do you have?*)
9. a) Are you presently using any method to delay or avoid pregnancy? ___ Yes ___ No

9. b) If yes, which method are you (or your partner) using?
 _____ Pill _____ Condom _____ Foaming tablets _____ Injections
 _____ IUD _____ Norplant _____ Permanent method _____ Other (specify) _____
- c) If no, why not? _____
10. How long have you been volunteering as a CBD?
 (Please write number of years. If less than one year, record number of months) _____
11. Do you also distribute:
 _____ Anti-malaria drugs (chloroquine) _____ TB drugs (DOTS)
 _____ Other (please specify) _____
12. In a normal week, approximately how much time, including travel time, do you spend doing CBD work? (Please probe for an **approximate** number of **hours**) _____
13. Suppose a person in your parish shows interest in using family planning. What is the average amount of time you will spend counselling this **new** client? (Please probe for an **approximate** number of total **minutes**.) _____
14. What is the longest travel time, one way, for the client who lives furthest away from you? (Please probe for an estimate for **minutes** for **one way**) _____
15. How many minutes did it take you to walk here for this meeting today? (Please probe for an estimate, in **minutes**, for **walking one way**) _____
16. When you are meeting a new client for the first time, which family planning methods do you tell him/her about? (Please allow CBD to respond freely, tick any of the following methods mentioned)
 _____ Pill _____ Condom _____ Foaming tablets
 _____ Injections _____ IUD _____ Norplant
 _____ Permanent method _____ Other (please specify) _____
17. You have just told me which methods you tell new clients about.
 Suppose a person is interested in family planning. You are meeting this person for the first. Tell me all the things (other things besides the types of methods available) that you will talk about or ask the client from the beginning to the end of this meeting. (Please allow CBD to respond freely, tick if any of the following answers are given by the CBD but do not probe.)
 _____ ask how many children the client wants to have
 _____ ask about the health of the client
 _____ ask about previous use of family planning
 _____ tell the client about how the methods works in the body to prevent pregnancy
 _____ tell the client how to use the method
 _____ tell the client about possible side effects of the methods
 _____ tell the client when to come back for a repeat visit
 _____ Other (please specify) _____
18. Please tell us if you also normally/generally talk about these other health topics with your clients.
 (Please read each of the following and circle **yes** or **no**)
- | | | | | | |
|-------------------------------------|-----|----|--------------------|-----|----|
| Nutrition | Yes | No | Breastfeeding | Yes | No |
| Immunization | Yes | No | Hygiene/sanitation | Yes | No |
| Other topics (please specify) _____ | | | | | |

19. When you are providing condoms to a **new** user, what do you tell them to ensure correct use?
(Please allow CBD to respond freely, tick if any of the following responses are given by the CBD)
- ☐ To check expiry date or damage to package
☐ How to open package carefully / how to remove condom from package carefully
☐ How to put the condom on the penis
☐ To remove the condom carefully immediately after sex
☐ To throw the used condom down the latrine
☐ Other (please specify) _____
20. From the following answers, when is the **best** time for a woman to begin using a new family planning method? (Please read the possible answers and ask respondent to select **one** answer)
- ☐ During her menstrual period
☐ Right after her period has ended
☐ Right before her period begins
☐ Don't know / don't remember
21. Most women can take the pill but some women should not be given the pill as a family planning method. Please answer yes or no to the following questions:
- | | | |
|--|------------------------------|-----------------------------|
| Can a woman over the age of 35 take the pill? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Can adolescents use the pill? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Can a pregnant woman use the pill? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Can a woman with heart problems or high blood pressure use the pill? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Can a woman with TB use the pill? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
22. Imagine/suppose a client has been using contraceptive pills for 2 months and she tells you that she is having headaches and nausea. What would you tell her? (Please allow CBD to respond freely, tick if any of the following answers are given by the CBD.)
- ☐ symptoms become less or stop within three months after starting contraceptives
☐ stop taking pills
☐ refer to another health worker
☐ other (please specify) _____
23. Who usually decides on the time and place of meetings between you and your clients? (Please read possible answers and ask CBD to select one answer.)
- | | |
|--|---|
| <input type="checkbox"/> You, the CBD | <input type="checkbox"/> The client |
| <input type="checkbox"/> You and the client together | <input type="checkbox"/> Other (please specify) _____ |
24. a) Are any of your clients under the age of 18? ☐ Yes ☐ No
- b) If no, why not? (please probe to assess if it is an issue with the adolescents or the CBD)
- _____
25. Are any of your female clients using family planning but keeping it a secret from their husbands?
☐ Yes ☐ No
26. a) When you refer clients to a health worker, do they usually comply?
☐ Yes ☐ No
- b) If not, what are their reasons? _____

27. In the last 6 months, what problems have you experienced in receiving supplies of contraceptives that you needed for your clients?
-
-
28. Do your clients offer you something (money or in-kind) for your services?
-
-
29. Do you feel you need to receive more support (for example, more visits, more supervision, guidance or assistance) from the trainer (nurse/supervisor) in order to do a better job as a CBD?
_____ Yes _____ No
30. Do you feel that the training you received in order to become a CBD was enough for you to do a good job?
_____ Yes _____ No
31. Would you like to have more training?
_____ Yes _____ No
- If yes, in what? (please specify) _____
32. a) Do you have enough information, education and communication (IEC) materials to help you with your work as a CBD ?
_____ Yes _____ No
- b) If no, what else do you think would help you with your work?
-
33. Do you think that your work as a CBD is making a positive change (making an impact or difference) to the health of families in your parish?
_____ Yes _____ No
34. How has being a CBD impacted/changed/improved your life? (What have been the personal benefits to being a CBD?)
35. a) Do you plan to remain an active CBD in the next one year?
_____ Yes _____ No
- b) If no, why not?
-
36. In your parish, who or what prevents people from using and continuing to use family planning? *(First allow client to respond freely. If necessary, please probe by giving some examples, religion, community leaders, husbands, cultural beliefs, fears etc.)*

37. **This question is in two parts:**
- a) What are the main problems you face in your work as a CBD? *(Interviewers: please allow the CBD to respond freely. If necessary, probe for comments on the following potential problems: motivation (transport, lunch/travel allowance), supplies, relationships with health unit personnel, recognition by community leaders, harassment from religious opposition.)*
- b) What are your suggestions on how to solve these problems and improve your work as a CBD? *(Please encourage CBD to offer ideas for solving each problem listed above.)*

Problem

Suggested solution (please try to be specific)

38. *Opportunity for last comments. Besides what we have already talked about, is there anything else you would like to say about the CBD program or about your work as a CBD? (Please encourage CBDs to provide other ideas on how to improve the CBD program).*

Appendix 8

CBD Client Questionnaire

Interviewer, before beginning the questionnaire, please:

- Confirm that the respondent is presently using FP and CBD services;
- Review the consent form with the respondent and request a signature;
- Tell the respondent that most questions simply require them to answer yes or no or to select one answer. There are also some open questions that ask for their suggestions and opinions.

County: _____	Sub-County: _____
Questionnaire number: _____	Date: _____
Sex of respondent: Male _____	Female _____
Name of interviewer: _____	

1. How old are you? _____ (years)
2. What is your ethnic group (tribe)?
 ___ Mutooro ___ Mukiga ___ Other (please specify) _____
3. What is your religion?
 ___ Catholic ___ Protestant (Anglican / Church of Uganda)
 ___ Muslim ___ Other (please specify) _____
4. What is the highest level of school you attended?
 ___ None ___ Primary ___ Lower Secondary (S1-4)
 ___ Upper secondary (S5-6) ___ Post-secondary (Vocational College/ University)
5. a) What is your marital status?
 ___ Single ___ Married ___ Divorced / Separated ___ Widowed
 b) If married, in polygamy or monogamy? _____
6. Does your household have a radio? ___ Yes ___ No
7. What is your job? (*ask about the job of the respondent only, not spouse*)
 ___ Farming/peasant/cultivating ___ Animal husbandry
 ___ Business/service/selling ___ Other, please specify _____
8. a) How many pregnancies have you had in your life in total? _____
 (*For men, ask how many children do you have?*)
 b) How many more children do you wish to have? (*if none, write 0*) _____

9. How did you first find out that CBD family planning services were available in your area?
 ___ Husband/wife ___ CBD ___ Health worker (not the CBD)
 ___ Family members ___ Friends ___ Radio ___ Other (specify) _____
10. In the last 6 months, have you experienced any problems in accessing the CBD when you needed his or her services? ___ Yes ___ No
11. a) In the last 6 months, have you experienced any problems in receiving supplies of contraceptives from the CBD when you needed them? ___ Yes ___ No
 b) If yes, what problems? _____
12. Who usually decides on the time and place of meetings between you and your CBD? *(Please read possible answers and ask client to select one answer.)*
 ___ You, the client ___ The CBD
 ___ You and CBD together ___ Other (specify) _____
13. Do you know when you have to next visit the CBD for more FP supplies?
 ___ Yes ___ No
14. a) Do you give the CBD any payment (money or in-kind) for FP services?
 ___ Yes ___ No
 b) If yes, how much or what do you give? _____
 c) If no, would you be willing to pay for CBD services, if requested to do so?
 ___ Yes ___ No
15. a) When you first began talking to the CBD about family planning, did the CBD ask you if you wanted to have more children? ___ Yes ___ No
 b) When you first began talking to the CBD about family planning, did the CBD ask you about your past experiences with family planning? ___ Yes ___ No
16. When you first began talking to the CBD about family planning, did the CBD give you information about the different types of family planning methods and how they work?
 ___ Yes ___ No
17. Which family planning methods did the CBD tell you about? *(Please allow client to respond freely, tick any of the following methods mentioned)*
 ___ Pill ___ Condom ___ Foaming tablets
 ___ Injections ___ IUD ___ Norplant
 ___ Permanent method ___ Other _____
18. Which method are you using now? _____
19. For how many months have you been using (client's METHOD) **continuously**?
 Months _____ *(if less than one month, record 00)*

20. Who made the final decision about using this family planning method?
☐ You, the client ☐ The CBD
☐ The client's spouse ☐ Other (please specify) _____

21. a) Do you plan to continue to use this method and the CBD program for the next one year?
☐ Yes ☐ No

b) If no, why not? _____

This question is for women only:

22. a) Does your husband/partner know that you are using a family planning method now?
☐ Yes ☐ No

b) If no, why does your husband not know or not approve of you using family planning?

23. Has the CBD given you any information about the possible side effects (disadvantages or problems) of the family planning method you are using?
☐ Yes ☐ No

24. a) Do you ever experience (or have you experienced) any problems or side effects with your family planning method? ☐ Yes ☐ No

b) If yes, what problems have you had?

- c) If yes, did you receive help/advice from the CBD on how to deal with side effects?
☐ Yes ☐ No

25. When the CBD explains something to you, does she use words and ideas that are clear and easy to understand? ☐ Yes ☐ No

26. Please tell us if you also normally/generally talk about any of these other health topics with your CBD. (Please read each of the following and circle yes or no)

Nutrition	Yes	No	Breastfeeding	Yes	No
Immunization	Yes	No	Hygiene/sanitation	Yes	No
Other topics (please specify) _____					

27. Has the CBD ever talked to you about sexually transmitted diseases, HIV or AIDS?
☐ Yes ☐ No

28. Is (add client's method here) effective in preventing STDS or HIV/AIDS?
☐ Yes ☐ No

29. Do you think it is possible for a person to have an STD or HIV and still look healthy?
☐ Yes ☐ No

30. Do you think family planning methods can make a woman weak or decrease her health?
☐ Yes ☐ No

31. Do you think that adolescents in Kabarole should use family planning?
☐ Yes ☐ No

32. Which do you think is more dangerous, giving birth or using contraceptives? _____
33. If there were other opportunities/possibilities, would you prefer to go somewhere else for family planning services other than the CBD?
 ____ Yes If yes, why? _____
 ____ No If no, why? _____
34. Have you ever recommended the CBD services to a friend, relative or anyone else?
 ____ Yes ____ No
35. Do you ever worry that the CBD will tell others that you are using family planning?
 ____ Yes ____ No
36. a) Overall, are you satisfied with the services provided by the CBD?
 ____ Yes ____ No
 b) If no, why not? _____
37. If you were requested to train and volunteer as a CBD, would you accept?
 ____ Yes ____ No
38. In your parish, who or what prevents/stops people from using and continuing to use family planning? *(First allow client to respond freely. If necessary, please probe by giving some examples, religion, community leaders, husbands, cultural beliefs, fears etc.)*
39. What do you like best or most about the CBD family planning program? *(First allow client to respond freely. If necessary, please probe by asking, for example, is it better to get family planning from the CBD or from a health unit? Tell me why it is better or more convenient/suitable for you to get family planning from the CBD than the health unit?)*
40. What are the difficulties or problems you face in receiving family planning services from the CBD and what would help you with these problems? *(please probe for a solution for every problem mentioned)*
- | <u>Problem</u> | <u>Suggested solution (please try to be specific)</u> |
|----------------|---|
| | |
41. *Opportunity for last comments. Besides what we have already talked about, is there anything else you would like to say about your experiences with family planning, the CBD or the CBD Program? (Please encourage clients to offer good or bad comments or to provide ideas on how to make the CBD program better).*

Appendix 9

Interview Guide for Focus Group Discussions (FGD) With CBD Volunteers

Note to facilitators: Please remember to do the following before beginning FGD:

- *Remind participants that the purpose of this discussion is to get their ideas and suggestions so that we can improve the family planning services in Kabarole. Please make it clear that this is a time for us to ask questions and get their answers. If they have questions about the program or about family planning, they will be given an opportunity to ask these at the end of the discussion.*
- *Ask participants to sign a consent form and explain why this is important.*
- *Tell participants that we will tape record the discussion and that there will be a person making notes of what is being said – but no names will be recorded.*
- *Remind participants that only one person should speak at a time and that all participants should have equal opportunity and feel comfortable to express their opinions.*

Questions about family planning and CBD in the parishes

1. What do you think stops or prevents people in your parishes from using family planning? Possible probes or examples: religion, community leaders, husbands, cultural beliefs, fears etc.
2. There are still many people in your parish who do not know about or do not use the CBD services. What are your suggestions on what we can do to get more people to use the CBD family planning services?
3. There are some people who begin using CBD but then they stop using the services. Do you know why people drop out of the program? Have you heard their reasons?
4. Often CBD agents receive training, begin working as a CBD Volunteer and then stop providing the services. Why do you think CBD Volunteer do not continue providing the services?
Probe: What stands out in terms of their dissatisfaction?

Assessing CBD satisfaction with CBD program:

What are the main benefits or advantages to having a CBD program in your areas?

Probe: What are the good things about the CBD program? Generally, does the CBD program contribute to the better health of women and the community? Generally, what are the community impressions of the CBD program?

Assessing client dissatisfaction with CBD program:

What are the main difficulties/problems you face as a CBD Volunteer?

Probes:

- Are there problems with the administration/implementation of the CBD program? (which can include training, supervision, payment, record keeping etc.)
- What things within the CBD program prevent you from doing a good job?
- What are the main barriers or constraints preventing you from doing a better job as a provider of family planning services?
- Do you meet regularly with colleagues, health staff and supervisors? Do you feel you need more supervision?
- Do you feel you need more training? If so, in what?

Recommendations:

If you were given the job of improving the CBD program, what would you do to make it a better program? What changes could we make in order to make sure people continue to use the CBD family planning services? How can the CBD program be improved so that is more accessible and acceptable to more women in this area and more satisfying for CBD Volunteers. What would the CBD program look like?

Probes:

- If you could make changes, what would they be? What message would you send to the director/manager/boss of the CBD program? What would ensure your continued working as a CBD Volunteer? What things would you suggest be changed?

Conclusion:

Are there any other concerns or suggestions you wish to express or questions you would like to ask?

Probe:

- Is there any other thing that I did not ask and that you would like to say?

Appendix 10

Interview Guide for Focus Group Discussions (FGD) With Former CBD Volunteers

Note to facilitators: Please remember to do the following before beginning every FGD:

- Remind participants that the purpose of this discussion is to get their ideas and suggestions so that we can improve the family planning services in Kabarole. Please make it clear that this is a time for us to ask questions and get their answers. If they have questions about the program or about family planning, they will be given an opportunity to ask these at the end of the discussion.
- Ask participants to sign a consent form and explain why this is important.
- Tell participants that we will tape record the discussion and that there will be a person making notes of what is being said – but no names will be recorded.
- Remind participants that only one person should speak at a time and that all participants should have equal opportunity and feel comfortable to express their opinions.

Introduction: We have been talking to CBD volunteers and CBD clients in Kabarole who are presently offering or receiving family planning services. However, we also feel it is important to talk to CBD volunteers who received training and worked for a time but then stopped working as CBD volunteers. Your opinions and suggestions, as past CBD workers will be very helpful to us.

1. We will begin by asking about your reasons for leaving the CBD program. Why did you stop working as a CBD? What do you think are the main reasons CBDs begin to work but then stop working as CBDs?
2. When you were working as a CBD, what were the problems or difficulties that you faced? Please probe to ask about a variety of possible problems – logistics such as transport but also support and supervision, training, lack of IEC materials/supplies, opposition in the community etc.
3. Based on your experiences what are the main things that stop or prevent people in your parishes from using family planning? Possible probes or examples: accessibility, religion, community leaders, husbands, cultural beliefs, fears etc.
4. Try to imagine that you have been given the job of improving the CBD program, what would you do to make it a better program? What changes would you make in order to ensure CBDs continue to work as CBDs? What would you do to make sure clients continue to use the CBD family planning services?
5. There are still many people in your parish who do not know about or do not use the CBD services. What are your suggestions on what we can do to get more people to use the CBD family planning services? Do you recommend the CBD program to others? What do you tell them? (Try to assess if CBD drop-outs are helpful or harmful to the CBD program)
6. When you were working as a CBD, what did you like best about the CBD program? Did you think that your work as a CBD was appreciated by the community and by BHS/GTZ/MOH?
7. Do you have any questions about the CBD program or about family planning in general?

Appendix 11

Interview Guide for Focus Group Discussions (FGD) With Adolescents

Note to facilitators: Please remember to do the following before beginning FGD:

- *Remind participants that the purpose of this discussion is to get their ideas and suggestions so that we can improve the family planning services in Kabarole. Please make it clear that this is a time for us to ask questions and get their answers. If they have questions about the program or about family planning, they will be given an opportunity to ask these at the end of the discussion.*
- *Ask participants to sign a consent form and explain why this is important.*
- *Tell participants that we will tape record the discussion and that there will be a person making notes of what is being said – but no names will be recorded.*
- *Remind participants that only one person should speak at a time and that all participants should have equal opportunity and feel comfortable to express their opinions.*

Re: Family Planning and Adolescents

1. Adolescents in Kabarole face serious physical, economic and social consequences from pregnancy and STDs. What is your opinion on this statement?

Probes: Do you think it is true or false? Why do you think it is true? Why do you say it is false? How serious a problem is unplanned or unwanted pregnancy for (girls/boys) in this area? How serious a problem are HIV/AIDS and STDs for (girls/boys) in this area?

2. If a male and a female want to delay, stop or prevent having children, what can they do?

Probes: If family planning mentioned: what is family planning? What does it mean? If family planning not mentioned: have you heard about family planning? What does it mean?

3. In this area, what kinds of things can/should/could a young (girl/boy) do if (she/he) wants to have sex but doesn't want to (become pregnant/make his partner pregnant)?

Probes: Anything else? What are the preferred methods or acceptable methods for adolescents? Are side effects or health problems resulting from use of methods a worry or concern for adolescents? If so, what are they?

4. Where do adolescents get their information about pregnancy and family planning in this area? Where do adolescents who use FP get their methods? Are you satisfied with the family planning information and services that are available for adolescents in this area? Is it difficult to get family planning services? What are the main problems (barriers or constraints) preventing adolescents in this area from accessing family planning services?

Probes: What do other community members (parents, teachers, health workers, other students) think of adolescents who use family planning methods? How are you treated by the staff at the health unit? Is there enough information available for adolescents?

Facilitator now provides a brief description of the CBD program offered by BHS.

Re: Adolescents and CBD

1. What do you think of this way of distributing family planning information and services and methods? Probes: have you ever heard of it before? Have you seen the CBD Volunteers working in the area? Do you know of anyone who uses this CBD service? Do you know any adolescents who use this service? Do you think adolescents would like to use it?
2. What would prevent adolescents from using CBD?
Probes: why don't adolescents use it? What would prevent adolescents from talking to a CBD Volunteer? What are the disadvantages to using it? What are the barriers to using it? Would you trust the CBD Volunteers/volunteers?
3. Suppose you were responsible for designing a new CBD program so that it was more accessible and acceptable to adolescents. What would the CBD program have to look like in order for adolescents to start using it and continue using it as their way of getting family planning information and services? Probe: where would the visits take place? When? What would be the characteristics of a good CBD Volunteer? Would it be a man or a woman? How old would she/he be? How would he/she help you? Would there be a cost? What would make you want to use it?
Probes: if the idea of peer educators / fellow students as CBDs is not mentioned by them, propose it and get their response to this idea.
4. Do you have any questions about the CBD program or about family planning in general?

Appendix 12

Interview Guide for Interviews with CBD Trainers

1. Let's begin by discussing family planning in general. From your perspective, are unplanned or unwanted pregnancies a serious problem in this area?
Probes: What prevents people from using family planning?
 What are the main things that stop people from using or continuing to use family planning?
2. Tell me about the CBD project in your sub-county.
Probes: What are the good things about the program in your area?
 What do you like most about it?
 What do community members like about it?
 Does it contribute to better health in the community? How?
 What do you think are the general community impressions of the CBD program?
3. Some CBD Volunteers receive training and work for awhile and then become inactive or leave the program altogether. Why do you think this is so? What do you think stands out in terms of their dissatisfaction?
4. Do the CBD Volunteers in your sub-county access adolescent clients? What do you think about this? Is it necessary to access more young people? How do you think this can be done?
5. What are the biggest challenges faced or problems experienced by your CBD Volunteers? Probes: does your group have enough training, supervision, supplies? Have they initiated income generating projects?
6. What about you as a CBD Trainer, what problems do you experience? Are there problems related to support from Basic Health Services or Local Councils?
7. What are your suggestions on how the CBD program can be improved to better meet the needs of clients and CBD Volunteers?
8. Do you have any final comments or questions?

Appendix 13

Interview Guide for Interviews with Local Council Representatives

1. Let's begin by discussing family planning in general. From your perspective, are unplanned or unwanted pregnancies a serious problem in this area?
Probes: What prevents people from using family planning?
 What are the main things that stop people from using or continuing to use family planning?
2. Can you tell me about the Community Based Distribution (CBD) Program in this area?
Probes: What are the good things about the program in your area?
 What do you like most about it?
 What do community members like about it?
 Does it contribute to better health in the community? How?
 What do you think are the general community impressions of the CBD program?
3. Some CBD Volunteers receive training and work for awhile and then become inactive or leave the program altogether. Why do you think this is so? What do you think stands out in terms of their dissatisfaction?
4. What prevents CBD Volunteers from reaching more people, from getting new clients or keeping clients?
5. What are the main issues or challenges faced by the CBD program or by CBD Volunteers?
Probes: are there important issues regarding training, supervision, support, logistics in the field etc?
6. What changes can be made to make the CBD program more acceptable and accessible to people in your area?
7. What support does (or has) the Local Council offer to the CBD Program? What support do you plan to offer in the future? Ideally, what support would you like to offer?
8. Do you have any questions for me regarding the CBD program or my research?
9. Are there any final comments that you would like to add?

Appendix 14

Cover Letter Accompanying Report of Initial Study Findings Forwarded to CBD Trainers

TO: CBD Trainers of Bukuuku, Butiiti, Katooke and Rwimi

FROM: Annette Flaherty
Department of Public Health, University of Alberta, Canada

DATE: December 8, 2000

Dear CBD Trainers,

I am happy to enclose a package of initial findings and results from my research entitled "Community-based family planning services in Kabarole: Assessing the experiences of those supplying and receiving services".

I have included an extra copy of this report in this package. Please forward it to the Clinical Officer in Charge at your Health Unit as soon as possible. A copy has also been forwarded to the Clinical Officers in Charge at the Health Sub District level.

I realize this may be a lot of reading but I felt that feedback for you and CBDs was a big priority. Please try to share this information with your CBDs during your monthly reporting meetings.

Enclosed please find:

- A description of the methodology used in the research;
- A summary of the results from the questionnaires administered to CBDs and clients. This includes some suggested actions where necessary;
- Tables of problems experienced in the CBD program as offered by Local Council Representatives, CBD drop-outs and CBD Trainers;
- Tables of recommendations for improving the CBD program as offered by Local Council Representatives, CBD drop-outs and CBD Trainers;
- A summary of the interview which took place with the Local Council Representative in your area;
- Major findings from focus group discussions with adolescents.

I hope you find this information interesting and educational. When I return to Canada, I will continue examining all of the good information I have collected and developing recommendations to improve the CBD program.

Thank you again for your cooperation and assistance with my research. Also, please remember to pass on my deep appreciation to the CBDs. The enthusiasm and commitment to family planning is greatly admired and appreciated.

Thank you,

Annette Flaherty

Appendix 15

Cover Letter Accompanying Report of Initial Study Findings Forwarded to Health Units

TO: Clinical Officer in Charge, Burahya Health Sub District
Clinical Officer in Charge, Mwenge South Health Sub District
Clinical Officer in Charge, Bunyangabu Health Sub District
Clinical Officers in Charge at Bukuuku, Butiiti, Katooke and Rwimi Health Units

FROM: Annette Flaherty
Department of Public Health
University of Alberta, Canada

RE: Findings from an investigation into the Community-Based Distribution (CBD)
Family Planning Program in Kabarole District

DATE: December 8, 2000

Dear Colleagues,

I have just completed a field research project entitled “Community-based family planning services in Kabarole: Assessing the experiences of those supplying and receiving services”. This research was carried out from September to November in conjunction with Basic Health Services.

Four CBD study sites were selected: Bukuuku, Butiiti, Rwimi and Katooke. Since this research was carried out in your areas of responsibility, the District Director of Health Services, Dr. Kabagambe and GTZ staff felt it was important for you to review the findings from this study.

Enclosed please find:

- A description of the methodology used in the research;
- A summary of the results from the questionnaires administered to CBDs and clients. This includes some suggested actions where necessary;
- Tables of problems experienced in the CBD program as offered by Local Council Representatives, CBD drop-outs and CBD Trainers;
- Tables of recommendations for improving the CBD program as offered by Local Council Representatives, CBD drop-outs and CBD Trainers;
- Summaries of interviews which took place with a Local Community Leader in your area;
- Major findings from focus group discussions with adolescents

I trust you will find this information interesting and informative. It is my hope that it will assist in increasing the enthusiasm and commitment to the CBD Family Planning program in Kabarole.

Please do not hesitate to contact Dr. Chris Baryomunsi at the office of the Director of Health Services if you have any questions or concerns.

Thank you,

Annette Flaherty

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